

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01516
CERTIFICATE OF DEATH
01560

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <u>8100 Harford Rd. Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8100 Harford Road</u>		d. STREET ADDRESS <u>3011 Mary Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Philip</u> Last <u>Ambrose</u>		4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-1-1915</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>
13. FATHER'S NAME <u>Philip S. Ambrose</u>		14. MOTHER'S MAIDEN NAME <u>Emma Nonnsen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>A. Raymond Bevans The Munsey Bldg.</u>	
17. INFORMANT <u>A. Raymond Bevans The Munsey Bldg.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1952</u> to <u>Feb. 1962</u> ; that (I) (we) last saw the deceased alive on <u>Feb 10, 1962</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William H. Hanes</u>		22b. DATE SIGNED <u>2/12/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>William H. Hanes</u>		22d. ADDRESS <u>8100 Harford Rd., Balt. 14 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>2-14-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard Francis Ruck</u>		25a. REC'D BY REGISTRAR <u>FEB 13 '62</u>	
ADDRESS <u>5305 Harford Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hanes</u>	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

0151

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01501

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN b 10 YRS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2023 OLD FREDERICK RD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HENRY R. ANDERSON SR.				4. DATE OF DEATH Month Day Year FEB. 22, 1962			
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 27, 1906	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAKE SALESMAN, WARD BAKING CO.				10b. KIND OF BUSINESS OR INDUSTRY VA.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HENRY ANDERSON				14. MOTHER'S MAIDEN NAME JANE DISHMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT MRS MARY F. ANDERSON, 2023 OLD FREDERICK RD.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO acute cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertension (c) Cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Geo. S. M. Kieffer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) GEO. S. M. KIEFFER MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/26/62		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMT.		22d. LOCATION (City, town, or country) (State) WOODLAWN MD.	
23. FUNERAL DIRECTOR WITZKE, 4101 EDMONDSON AVE.				24a. REC'D BY REGISTRAR FEB 26 '62			
				24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

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C. S. M. K. P. K. M. D.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Item 23 Film G309

CERTIFICATE OF DEATH

3/29/62 iwk

01502

01518

Item 24 & 14 Film G309

3/29/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN lb <u>5yrs 10 mos +</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hosp</u>				d. STREET ADDRESS <u>1247 Glyndon Ave</u>			
3. NAME OF DECEASED (Type or print) <u>John</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>18</u> Year <u>1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 1889</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Joseph Arnold</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: Spring Grove State Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>4-20-62</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic heart disease</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Gangrene of toe</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>56</u> to <u>Feb</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Feb. 18</u> 19 <u>62</u> , and that death occurred at <u>11:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/19/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar M.D.</u>				22d. ADDRESS <u>Spring Grove State Hospital</u> <u>Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 20, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Old Fred. Rd. Balto. Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Fred A. Krause</u>				ADDRESS <u>1216 S. Charles St. Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>Feb 26 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
Don't bury immediately

01203

01213



01519

CERTIFICATE OF DEATH

Reg. Dist. **01503**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Edgemere		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Edgemere	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11th Ave. at Millers Island Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AUGUST F. ARTKAMPER		4. DATE OF DEATH Month Feb. Day 14th Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1866
9. AGE (In years lost birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer-ret.		10b. KIND OF BUSINESS OR INDUSTRY St. Louis, Missouri	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Artkamper		14. MOTHER'S MAIDEN NAME Henrietta Steinmeyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Grace Peterson 11th Ave. at Millers Island Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Artemia DUE TO (b) Generalized Art. Scler. DUE TO (c) 15 yrs		INTERVAL BETWEEN ONSET AND DEATH 12 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-5 , 19 57 , to 2-14 , 19 62 , that I last saw the deceased alive on 1-2 , 19 62 , and that death occurred at 11 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack C Collins		DATE SIGNED 2-15-62	
PHYSICIAN'S NAME (Type) Jack C Collins		ADDRESS (Street, city or town, state) Baltimore Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 2/17/62	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		24a. REC'D BY REGISTRAR DATE FEB 19 1962	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1950

CERTIFICATE OF DEATH

1950



Handwritten signature

Handwritten signature

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **01504**

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHASE		c. LENGTH OF STAY IN 1b 40 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 331 CHASE MD.		d. STREET ADDRESS Box 331 CHASE MD.	
3. NAME OF DECEASED (Type or print) First Susanna Middle Austrow Last Austrow		4. DATE OF DEATH Month 2 Day 17 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		12. KIND OF BUSINESS OR INDUSTRY HOMEMAKER	
13. FATHER'S NAME HARRY BAMFORTH		14. MOTHER'S MAIDEN NAME JOSEPHINE CHARLESWORTH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT William Harry Austrow Jr		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (a) _____ (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Jack E Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JACK E COLLINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-17-66	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/20/1966	
22c. NAME OF CEMETERY OR CREMATORY ZION LUTHERAN CEM.		22d. LOCATION (City, town, or county) (State) GOLDEN RING RD MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Jessie Funeral Home 7401 Belair Rd E		ADDRESS 7401 Belair Rd E	
24a. REC'D BY REGISTRAR DATE FEB 19 '66		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form No. 10-5014

350



NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CITY	
OCCUPATION		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY	
HISTORY OF PRESENT ILLNESS		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
TREATMENT		POSTMORTEM EXAMINATION		FINDINGS	
SIGNATURE OF EXAMINER		DATE		PLACE	

RE 1 MARYLA
01505

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/60

01202

01202

(M)

Belmont

For Howard

AS DEPT

Yosemite National Park

John

Walter

Walter

Walter

Walter

Walter

Walter

Walter

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W I

RECEIVED DIRECTOR, FBI, WASHINGTON, D.C.
JAN 10 1964
FBI WASHINGTON

OLD HEADQUARTERS - WASHINGTON, D.C.

Handwritten signature

Walter

Walter

Walter

Walter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01522

CERTIFICATE OF DEATH

01506

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 34 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 15 d. STREET ADDRESS 5015 Queensberry Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EARL C. BAKER		4. DATE OF DEATH Month Day Year February 27 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 23, 1893
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days 1 1	11. IF UNDER 24 HRS. Hours Min. 10 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Glenrock, Pennsylvania	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard Baker		14. MOTHER'S MAIDEN NAME Mary Eppers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 213-10-4920	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) CARCINOMA OF ESOPHAGUS DUE TO (c) CARCINOMA OF THE TONGUE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF THE TONGUE	
19. INTERVAL BETWEEN ONSET AND DEATH 1 WK (approx.)		20. UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that 10 (this hospital) attended the deceased from Jan 24 , 19 62 to Feb 27 , 19 62 that 24 (we) last saw the deceased alive on Feb 27 , 19 62 , and that death occurred at 10:55 AM from the causes and on the date stated above.			
22a. SIGNATURE P. G. KOUKOUZAS, M. D.		22b. DATE SIGNED 2/27/62	
22c. PHYSICIAN'S NAME (Type) P. G. KOUKOUZAS, M. D.		22d. ADDRESS VAH, BALTO 18 MD. FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/2/62	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE C. VERNON LEMMON		25a. REC'D BY REGISTRAR MAR 1 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. K...			

VR A15 (4)
15M 9/60

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01507

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson				c. LENGTH OF STAY IN 1b 2 hrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Landsdowne			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Wilson State Hospital								d. STREET ADDRESS 224 Elizabeth Avenue			
3. NAME OF DECEASED (Type or print) Charles Andrew Barbee				4. DATE OF DEATH 2/ 16 19 62				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 30, 1907		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles A. Barbee						14. MOTHER'S MAIDEN NAME XXXXXXXXXXXX Mollie Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 212-07-1169		17. INFORMANT Address Hospital records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic alcoholism										INTERVAL BETWEEN ONSET AND DEATH 8 yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE D.D. Caples				M.D. D.D. Caples, M.D.				DATE SIGNED 2/16/62			
EXAMINER'S NAME (Type) D.D. Caples, M.D.				Address (Street, city, town, or county) Reisterstown, Md.							
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/62		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				22d. LOCATION (City, town, or country) Baltimore, Md.			
23. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave.						24a. REC'D BY REGISTRAR DATE FEB 19 '62		24b. REGISTRAR'S SIGNATURE Charles L. Fenn			

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ORIGINAL: 100-100000

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may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01524

01508

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md		b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 8mo. 26day.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 439 N. Lakewood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Kathryn Barry		First Middle Last		4. DATE OF DEATH 2 14 1962		Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/26/1878		9. AGE (In years last birthday) yrs. 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Barry				14. MOTHER'S MAIDEN NAME Julie Lucy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 12 mo					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Far Advanced Pulmonary Tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 00001					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 00001	
21. I certify that (I) (this hospital) attended the deceased from 5/19 1961 to 2/14 1962 that (I) (we) last saw the deceased alive on 2/14 1962 , and that death occurred at 7:40 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer				22b. DATE SIGNED 2/14/62			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M. D. Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 17, 1962		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John A. Moran				25a. REC'D BY REGISTRAR FEB 20 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

01308

DECLARATION OF ORIGIN

01308

01525

CERTIFICATE OF DEATH

01509

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 21 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7 d. STREET ADDRESS 3911 Liberty Heights Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LILBOURN I. BEANS				4. DATE OF DEATH February 27 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 19, 1892	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker				10b. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (County & State, or foreign country) Rio de Janeiro, Brazil	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Henry Beans			
14. MOTHER'S MAIDEN NAME Barbara Buchheimer				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I			
16. SOCIAL SECURITY NO. None				17. INFORMANT Clinical Records VAH, Baltimore 18, Md., Fort Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL LOBAR PNEUMONIA DUE TO 490 X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 Days +						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 6, 1962 , to February 27, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 27, 1962 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED 2/28/62		22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.	
22d. ADDRESS VAH, BALTIMORE, MARYLAND, FT. HOWARD DIVISION				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-2-62		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc.				25a. REC'D BY REGISTRAR 5 '62		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01503

01503

Veterans Administration Hospital
 5015 Highway 101, N. W.
 Washington, D. C. 20422

Mr. J. H. ...
 1015 Highway 101, N. W.
 Washington, D. C. 20422

WASHINGTON POST, FEBRUARY 17, 1962

John O. McNeill & Sons, Inc.
 1015 Highway 101, N. W.
 Washington, D. C. 20422

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01526						01510					
1. PLACE OF DEATH e. COUNTY BALTIMORE f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD g. LENGTH OF STAY IN 1b 55 days h. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE MARYLAND f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE g. STREET ADDRESS 3315 Batavia Avenue h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LOUIS H. BELZ						4. DATE OF DEATH Month February Day 24 Year 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 8, 1879		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10b. KIND OF BUSINESS OR INDUSTRY Public		11. BIRTHPLACE (County & State, or foreign country) Germany			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Julius Belz						14. MOTHER'S MAIDEN NAME Ida Bohrig					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Spanish American						16. SOCIAL SECURITY NO. 212-03-7259 Informant Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF CECUM DUE TO ADENOCARCINOMA OF CECUM Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 153.0 DUE TO ADENOCARCINOMA OF CECUM (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Dec 31, 1961 to Feb 24, 1962		(County)		(State)	
21. I certify that 10 (this hospital) attended the deceased from Dec 31, 1961 to Feb 24, 1962 , that (I) (we) last saw the deceased alive on Feb 24, 1962 , and that death occurred at 8 AM , from the causes and on the date stated above.											
22a. SIGNATURE Jose L. Valdes M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) JOSE L. VALDES, M.D.						22d. ADDRESS VAH, Balto. 18 Md., Ft Howard Division					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/28/62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) Baltimore 28, Maryland		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford Road Baltimore, Md.				25a. REC'D BY REGISTRAR FEB 27 1962		25b. REGISTRAR'S SIGNATURE William S. Thomas	

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January 2, 1919

Germany

Public

Room

The House

For Special Session 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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Item 8 Film 0307
2/13/62
01511
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 31yr8mth7days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY -							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 2700 Christopher Avenue		3. NAME OF DECEASED (Type or print) First Anna Middle Boehm Last		4. DATE OF DEATH Month February Day 4 Year 19 62							
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 6, 1902		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) factory worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? Austria USA		13. FATHER'S NAME Frank Boehm		14. MOTHER'S MAIDEN NAME Clara VanDeame					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic cardiovascular disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (this hospital) attended the deceased from May 27 1962 to Feb. 4 1962 that (I) (we) last saw the deceased alive on Feb. 4 1962, and that death occurred at p.m. from the causes and on the date stated above.		22a. SIGNATURE Bruno Radauskas M.D.		22b. DATE 2-5-62		22c. PHYSICIAN'S NAME (Type) Bruno Radauskas, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL catonsville 28, Maryland		22e. REC'D BY REGISTRAR DATE FEB 8 '62		22f. REGISTRAR'S SIGNATURE Arthur S. Thomas			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/8/62		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City, town or county) (State) BALTIMORE Md		23e. FURNERAL DIRECTOR'S SIGNATURE A. J. Ruck		23f. ADDRESS 5305 HARFORD Rd.		23g. DATE FEB 8 '62		23h. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01528 CERTIFICATE OF DEATH 01512

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>7827 Wendover Road</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> d. STREET ADDRESS <i>7827 Wendover Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mr. Steve</i> First Middle Last 4. DATE OF DEATH <i>February 24, 1962</i> Month Day Year		5. SEX <i>male</i> 6. COLOR OR RACE <i>white</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <i>Apr. 27, 1884</i> 9. AGE (in years last birthday) <i>77</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Emp. of Wienton Steel Co</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Yugoslavia</i> 11. BIRTHPLACE (County & State, or foreign country) <i>U.S.A.</i> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Ret. Unknown</i> 14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. <i>232405-8116A</i> 17. INFORMANT <i>Mrs. Mildred Lowe</i> Address <i>same</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malignant Cancerous</i> <i>157 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Cancer of pancreas</i> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 1955</i> to <i>Feb 1962</i> , that (I) (we) last saw the deceased alive on <i>Feb 14, 1962</i> , and that death occurred at <i>8:00 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>William J. Jones</i> M.D. 22b. DATE SIGNED <i>Feb 14 1962</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>William J. Jones</i>		22d. ADDRESS <i>800 Harford Rd - Balt 14 West</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>2/28/62</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i> 23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>		24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck Inc. 5305 Harford Road.</i> ADDRESS <i>5305 Harford Road.</i> 25a. REC'D BY REGISTRAR <i>Feb 27 '62</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01529 CERTIFICATE OF DEATH 01513

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> <u>3401-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Chapel Hill Convalescent Home</u>		d. STREET ADDRESS <u>6900 Glen Oak Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Freda</u> Middle <u>R.</u> Last <u>Boileau</u>		4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-1874</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry Sheer</u>	
14. MOTHER'S MAIDEN NAME <u>Louisa Merkel</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknwn) <u>-</u>	
16. SOCIAL SECURITY NO. <u>179077955D</u>		17. INFORMANT <u>Norman Boileau</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>-</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>-</u> p.m. <u>-</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	
20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>		21. I certify that (I) (this hospital) attended the deceased from <u>August 2/10/62</u> to <u>February 1962</u> , that (I) (we) last saw the deceased alive on <u>2/10/62</u> , and that death occurred at <u>5:30AM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Millard T. Traband, Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2/15/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Millard T. Traband, Jr.</u>		22d. ADDRESS <u>5101 Gwynn Oak Ave. Balt. 7, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>2-19-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>William Penn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Philadelphia, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc. 5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR <u>FEB 20 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Caroline P. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01530

01514

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Paradise Nursing Home</u>		d. STREET ADDRESS <u>817 Beaumont Avenue #12</u>	
3. NAME OF DECEASED (Type or print) <u>Lee</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 27, 1895</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert M. Bowen</u>		14. MOTHER'S MAIDEN NAME <u>Juliet A. Hewell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>World War I</u>	
17. INFORMANT <u>Mr. Clarence Bowen-817 Beaumont Ave. #12</u>		Address <u>#12</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> <u>Hemiplegic Right.</u> <u>Generalized Arteriosclerosis.</u> <u>chronic Brain Syndrome</u> Conditions, if any, which gave rise to immediate cause (b) <u>331 X</u> (c) <u>due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>11:45</u> p.m. <u>PM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2/13/62</u>		20f. (City or town) <u>Baltimore</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/13/62</u> to <u>2/13/62</u> , that (I) (we) last saw the deceased alive on <u>2/13/62</u> , and that death occurred <u>11:45 PM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>W.E. McGrath</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. PHYSICIAN'S NAME (Type) <u>W.E. McGrath</u>		22c. ADDRESS <u>1303 Frederick Rd (28)</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-16-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town or county) <u>Woodlawn, Maryland</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Roberts & Sons</u>		25. REC'D BY REGISTRAR <u>FEB 19 '62</u>	
ADDRESS <u>Suite 12, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Wm J. Roberts</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01531

CERTIFICATE OF DEATH

01515

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 3 Hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster d. STREET ADDRESS Route 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First HARRY Middle R. Last BOWMAN		4. DATE OF DEATH Month February Day 13 Year 19 62				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 4, 1920	9. AGE (In years last birthday) 41 yrs.	10. IF UNDER 1 YEAR Months 1 Days 1	11. IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worker		10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory		11. BIRTHPLACE (County & State, or foreign country) Westminster, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James M. Bowman		14. MOTHER'S MAIDEN NAME Julia Berwager		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		
16. SOCIAL SECURITY NO. 219-01-2051		17. ADDRESS Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSTEROLATERAL & INTERSEPTAL MYOCARDIAL INFARCTION DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) POSTERIOR DESCENDING CORONARY STENOSIS DUE TO (c) CORONARY SCLEROSIS INTERVAL BETWEEN ONSET AND DEATH FEW DAYS UNKNOWN						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EDEMA . ANGIOMA LIVER, SOLITARY						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 2:05 PM 2/13/62 to 2/13/62
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2:05 PM 2/13/62 to 2/13/62 , 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/13/62 , 19 62 , and that death occurred at 2:05 P.M. from the causes and on the date stated above.						
22a. SIGNATURE Sebastian Russo M.D.				22b. DATE SIGNED 2/14/62		22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.
22d. ADDRESS VAH, BALTO. 18 MD FT HOWARD DIVISION						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/17/62		23c. NAME OF CEMETERY OR CREMATORY Leisters Cemetery		23d. LOCATION (City, town or county) (State) Rural Westminster, Md.
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr.		ADDRESS Westminster, Md.		25a. REC'D BY REGISTRAR FEB 16 '62		25b. REGISTRAR'S SIGNATURE William L. Farris

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01532 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01516									
1. PLACE OF DEATH e. COUNTY Baltimore Co. MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Baltimore				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
Baltimore					Baltimore 6				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
5810 Fairview					3918 Frankford Ave.				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
RUDOLPH DONALD BRADFORD					Feb. 24 1962				
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
				July 26, 1930		31 yrs.		IF UNDER 1 YEAR Months Days	
								IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. BIRTHPLACE (State or foreign country)				
Construction worker					Baltimore, Maryland				
13. FATHER'S NAME					12. CITIZEN OF WHAT COUNTRY?				
Preston B. Bradford					U.S.A.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.				
no					220-20-2165				
17. INFORMANT					Address				
					Mrs. Margaret E. Silver, 6 Maple Avenue, Zone 6				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Acute Alcoholism									
322.0 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
Myocardial Hypertrophy									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
					By large quantity of alcohol				
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED				
1:00 p.m. Feb. 24, 62					While at work				
					Not While at work				
					Street				
					Balto. Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE H. Shaub					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
					DATE SIGNED Feb. 25, 1962				
22a. BURIAL, CREMATION, REMOVAL (Specify)					22b. DATE THEREOF				
BURIAL					2-28-62				
22c. NAME OF CEMETERY OR CREMATORY					22d. LOCATION (City, town, or country) (State)				
Glen Haven Cemetery					Glen Burnie, Maryland				
23. FUNERAL DIRECTOR					24a. REC'D BY REGISTRAR				
Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2					DATE 27 '62				
					24b. REGISTRAR'S SIGNATURE				
					Arthur L. Thomas				

01516



Construction worker
Frederic A. Bradford
120-40-1-103

2-23-42

Mr. Cook, Inc., 117 St. Paul St., Baltimore 2

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01533 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01517**

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GLENN L. MARTIN PLANT				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 5 d. STREET ADDRESS 1122 Hewitt Way e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) William Earl BRANHAM First Middle Last				4. DATE OF DEATH Month Feb , Day 6 , Year 19 62													
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 3, 1915		9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor Glenn L. Martin CO.				10b. KIND OF BUSINESS OR INDUSTRY Pounds Virginia				11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Oscar Branham						14. MOTHER'S MAIDEN NAME Laura Sowards											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes. 4/21/39 7/27/45						16. SOCIAL SECURITY NO. 214 26 7905						17. INFORMANT 1122 Hewitt Way Balto/5, Md. Mrs Emma Jean Branham					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 2 min					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.																	
ACTUAL SIGNATURE JACK E COLLINS						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED 2-6-62					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 2/9/62		22c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH				22d. LOCATION (City, town, or county) (State) BALTIMORE COUNTY MD.							
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE MD.						ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 8 '62		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Finner</i>							

TO FURNISH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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01534

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01518

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines		e. STREET ADDRESS 3701 Patterson Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edna Middle M. Last Bray		4. DATE OF DEATH Month February Day 22 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1884
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 12 Days 22 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Horace McCarty		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT C. E. Bray		Address 3701 Patterson Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 4-2-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chro. Atherosclerotic Cardio-Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 mo. 10 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-8-1961 to 2-22-1962 , that (I) (we) last saw the deceased alive on 2-22-1962 and that death occurred at 10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallager		22b. DATE SIGNED 2/27/62	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallager, M.D.		22d. ADDRESS 6209 Frederick Ave. Baltimore, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/26/62	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		25a. REC'D BY REGISTRAR FEB 27 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01519											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. LENGTH OF STAY IN 1b <u>42 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore Md.</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>22 Glenmore Ave.</u>						d. STREET ADDRESS <u>22 Glenmore Ave.</u>					
3. NAME OF DECEASED (Type or print) <u>Arthur</u> First <u>Howard</u> Middle <u>BUCHMAN</u> Last						4. DATE OF DEATH Month <u>Feb.</u> Day <u>10</u> Year <u>19 62</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-3-1919</u>		9. AGE (In years less birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Carrier</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Postal Serv.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Howard Buchman</u>						14. MOTHER'S MAIDEN NAME <u>Grace Lambert</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW 2</u>				16. SOCIAL SECURITY NO. <u>218-05-7008</u>		17. INFORMANT <u>Mrs. Nadia Buchman</u> <u>22 Glenmore Ave.</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>892.9</u> IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2/11/62</u> Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-14-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Balto., Md.</u>					
23. FUNERAL DIRECTOR <u>Assn. Fun. Home Hq. Balto. Md.</u> ADDRESS						24a. REC'D BY REGISTRAR <u>FEB 14 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Pinski</u>			

01219

11335



(Carbon monoxide poisoning)

R. J. Rostenberger, M.D.
R. J. Rostenberger

of the ...

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01536

01520

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 9 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 24 d. STREET ADDRESS 540 North Payson e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM T. BUTLER First Middle Last				4. DATE OF DEATH February 15 1962 Month Day Year			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 8, 1905	
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10b. KIND OF BUSINESS OR INDUSTRY Radiation Co.		11. BIRTHPLACE (County & State, or foreign country) Plymouth, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Butler	
14. MOTHER'S MAIDEN NAME Lilly Howard		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 078-18-8462		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBACUTE GLOMERULONEPHRITIS DUE TO WITH UREMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Uremic Pericarditis and Gastritis 2. Passive Congestion of Lung, liver and spleen							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 6, 1962 to February 15, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 15, 1962 , and that death occurred at 6:10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/15/62	
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.				22d. ADDRESS VAH, BALTO. 18, MD., FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-19-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) Baltimore 28, Maryland (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson Funeral Home				25a. REC'D BY REGISTRAR FEB 20 '62		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(1)

01538

01538

Baltimore

Baltimore

Bone Howard

9 Days

Veterans Administration Hospital

940 North Peyton

WINTER

WINTER

T.

February 12

Male

Height

July 8, 1905

25

Laborer

Recreation Co.

Pymouth, Virginia

U. S. A.

John Butler

John Butler

Yes

W II

075-15-755

U.S. Army, Fort Howard Division

RECEIVED AND FORWARDED
WITH URGENCY

URGENT

1. Please refer to file and distribute to Bureau, Congress of House,
House and Senate

x

February 12

February 12

February 12

SENATOR HUBB, M.D.

WAR, BALTO. 10, MD., FORT HOWARD DIVISION

2-17-62

1000 Maryland Ave.

Mr. J. O. Walsh Funeral Home

Baltimore 17, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01537

01521

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. LENGTH OF STAY IN 1b <u>5 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>		d. STREET ADDRESS <u>Rt. 2 Box 148</u>	
3. NAME OF DECEASED (Type or print) <u>CLAUDE THOMAS CARPENTER</u>		4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-1893</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GAS COMPANY</u>	
11. BIRTHPLACE (State or foreign country) <u>Petersburg, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY McLEANE</u>		14. MOTHER'S MAIDEN NAME <u>LEONA BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>379-85-0086</u>	
17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced pulmonary tuberculosis</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (d) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema, compensatory severe</u>		INTERVAL BETWEEN ONSET AND DEATH <u>22 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-21-1961</u> to <u>2-20-1962</u> that (I) (we) lost the deceased alive on <u>2-20-1962</u> and that death occurred <u>9:50</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William Newcomer</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u>		22b. DATE SIGNED <u>Feb 26 '62</u>	
22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>Feb. 23, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Heath Tharred Home, Waldorf Md</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 26 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>James S. Kraus</u>	

01551

EXETER, N.H. 03183

1987

(M)



(1)

EXETER, N.H.



EXETER, N.H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01538

CERTIFICATE OF DEATH

01522

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY in 1b 4 1/2 yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School		d. STREET ADDRESS 529 N. Carrollton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eugene Casley		4. DATE OF DEATH February 10, 1962		5. SEX Male	
6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/12/53	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years of last birthday) 8 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Johnnie Casley	
14. MOTHER'S MAIDEN NAME Blanche Livers		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Clinical record at Rosewood		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Bilateral Broncho pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral atrophy, microcephaly, epilepsy		INTERVAL BETWEEN ONSET AND DEATH 1 hr 20 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that (this hospital) attended the deceased from Aug 12, 1957 to Feb 10, 1962 that (we) last saw the deceased alive on Feb 10, 1962 , and that death occurred at 9:55 PM , from the causes and on the date stated above.					
22a. SIGNATURE Edward J. Mathews		M.D. Edward J. Mathews, M.D.		22b. DATE SIGNED 2-11-62	
22c. PHYSICIAN'S NAME (Type) Edward J. Mathews, M.D.		22d. ADDRESS Rosewood State Training School Owings Mills, Md.		22e. ADDRESS Rosewood State Training School Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 2/14/62		23b. DATE THEREOF 2/14/62		23c. NAME OF CEMETERY OR CREMATORY 2nd Baptist	
23d. LOCATION (City, town or county) Baltimore		23e. (State) Md.		23f. (Country) U.S.A.	
24. FUNERAL DIRECTOR'S SIGNATURE Isaiah L. Brown		24a. ADDRESS Isaiah L. Brown		25a. REC'D BY REGISTRAR FEB 19 62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. (City, town or county) Baltimore		25d. (State) Md.	

01935

01935

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01539

CERTIFICATE OF DEATH

01523

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>Shady Nook Convalescent Home</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> d. STREET ADDRESS <u>2109 Lukewood Drive #7</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louise L. Cassels</u> 4. DATE OF DEATH Month Day Year <u>February 18 19 62</u>													
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1870</u>		9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wisconsin</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>J. M. Chambers</u>				14. MOTHER'S MAIDEN NAME <u>Jane E. ?</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Robert C. Cassels-2109 Lukewood Drive #7</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> <u>1 month</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from <u>June 28</u> <u>1961</u> , to <u>Feb. 18</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>Feb. 17</u> <u>1962</u> , and that death occurred at <u>1030M</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>George A. Knipp</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>February 19, 1962</u>							
22c. PHYSICIAN'S NAME (Type) <u>George A. Knipp</u> M.D.				22d. ADDRESS <u>4116 Edmondson Ave.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2-21-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematory</u> <u>Baltimore, Md.</u>		23d. LOCATION (City, town or county) (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker</u> ADDRESS <u>Baltimore 17, Md.</u>				25a. REC'D BY REGISTRAR <u>Feb 20 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Tucker</u>							

01983

01983



George R. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01540

01524

1. PLACE OF DEATH e. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3mth18dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Maryland		1653-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 425 4th Allen Avenue		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Virginia Jessamine Charles		4. DATE OF DEATH Month Day Year February 26 19 62					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 3, 1883	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerical		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Alvin W. Gaves		14. MOTHER'S MAIDEN NAME Landonia Dutton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia DUE TO 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic cardiovascular disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (X) (this hospital) attended the deceased from Dec. 8, 1961 to Feb. 26, 1962 that (I) (we) last saw the deceased alive on Feb. 26, 1962, and that death occurred at 9:00 M, from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar M.D.				22b. DATE SIGNED 2-26-62			
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL CATONSVILLE 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3-1-62		23c. NAME OF CEMETERY OR CREMATORY GOOD-HOPE CEMT, NEWBURG MD.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE J. W. = Lees Wash. D. C.				25a. REC'D BY REGISTRAR DATE FEB 28 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

01310

UNITED STATES OF AMERICA

01310



RECEIVED 01-12-1960
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

01541

CERTIFICATE OF DEATH

Reg. Dist. No. 01525

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. LENGTH OF STAY IN 1b <u>33 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chittenden Lane</u>				d. STREET ADDRESS <u>Chittenden Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Ward</u> Last <u>Chittenden Jr.</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>14</u> Year <u>1962</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 10, 1896</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate - Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Henry Ward Chittenden</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Sherrrey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>213-01-2108</u>		INFORMANT Address <u>John F. Chittenden 507 Edgemoor Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>4-20-0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5 July 1949</u> to <u>Feb 14, 1962</u> that I last saw the deceased alive on <u>Jan 19 62</u> , and that death occurred at <u>8 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul H Royse</u> M.D. <u>1403 Foley Lane</u>				DATE SIGNED <u>14 Feb 62</u>			
PHYSICIAN'S NAME (Type) <u>PAUL H ROYSE MD. Pikesville 8 Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-16-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas'</u>		22d. LOCATION (City, town, or county) (State) <u>Garrison Forest Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.W. Jenkins f Sons Co. 4905 York Rd.</u>				24a. REGISTERED REGISTRAR DATE <u>FEB 15 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01533

CERTIFICATE OF DEATH

01533

(M)

DATE

MO

CAUSE OF DEATH

AGE

SEX

PLACE OF DEATH

DATE OF DEATH

NAME OF DECEASED

DATE OF BIRTH

NO

US

STATE

CITY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01542

01526

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) TOWSON CONVALESCENT HOME		d. STREET ADDRESS 300 SOUTH WINDWOOD ROAD	
3. NAME OF DECEASED (Type or print) First EDITH Middle E. Last CHURCHILL		4. DATE OF DEATH Month FEBRUARY Day 3 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 24, 1876
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY BROWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FAMILY RECORDS -		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensative Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arterio sclerosis - Hemiplegia (Rt.) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from June 10, 1960 to Feb 3, 1962 , that (I) (we) last saw the deceased alive on Feb 3, 1962 , and that death occurred at 4:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Laurence C. Post		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) LAURENCE C. POST		22d. ADDRESS 6805 York Rd. Baltimore 12 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL/BURIAL FEB. 6, 1962		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY HACKENSACK CEMETERY		23d. LOCATION (City, town or county) (State) HACKENSACK, NEW JERSEY	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Son, Towson, Md.		25a. REC'D BY REGISTRAR DATE FEB 9 '62	
25b. REGISTRAR'S SIGNATURE William S. Evans			

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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01543
CERTIFICATE OF DEATH
01527

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orlando 48X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Foxleigh Convelescent Home				d. STREET ADDRESS Formerly of Orlando, Florida			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Anne Middle J. Last Clark				4. DATE OF DEATH Month February Day 3 Year 19 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 12, 1876	
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retried Homemaker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME James Moses				14. MOTHER'S MAIDEN NAME Elizabeth ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. E. L. Grimes-Golf Course Rd-Owings Mills, Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 425 yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 19 Dec , 19 61 , to 3 Feb , 19 62 that (I) (we) last saw the deceased alive on 31 Jan , 19 62 and that death occurred at 4 AM , from the causes and on the date stated above.							
22a. SIGNATURE Paul H Royse				22b. DATE SIGNED Feb 3, 1962			
22c. PHYSICIAN'S NAME (Type) PAUL H ROYSE				22d. ADDRESS 1403 Foley Lz Pikesville 8 Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-5-62		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Johnson & Sons Baltimore 12 Md.				25a. REC'D BY REGISTRAR DATE FEB 5 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

01527

CERTIFICATE OF DEATH

01527



MADE IN
BOX COLTOP
01527

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01544

CERTIFICATE OF DEATH

01528

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE SUB		c. LENGTH OF STAY IN 1b 5 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1201, CAPTAIN'S COURT,		d. STREET ADDRESS SUNSET BEACH, PASADENA	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle MARY Last CHECKNER		4. DATE OF DEATH Month FEB. Day 22 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 7, 1901
9. AGE (In years last birthday) 60/61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME JOSEPH DUNN		14. MOTHER'S MAIDEN NAME Not known.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT MR THOMAS CHECKNER		Address 1201, CAPTAIN'S COURT, #1, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory Infection (c) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 18, 1962 , to Feb. 21, 1962 , that (I) (we) last saw the deceased alive on Feb. 20, 1962 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE Keith A. Manley		22b. DATE SIGNED Feb 22, 1962	
22c. PHYSICIAN'S NAME (Type) KEITH A. MANLEY		22d. ADDRESS 1034, YORK ROAD TOWSON, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 26, 1962	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.		23d. LOCATION (City, town, or county) (State) Ritchie Hwy. A. A. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce		25a. REC'D BY REGISTRAR DATE FEB 27 '62	
ADDRESS 4001 Ritchie Hwy. (25)		25b. REGISTRAR'S SIGNATURE Arthur S. Haines	

George J. Gonce

01352

STATE OF CALIFORNIA

01352

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01545

CERTIFICATE OF DEATH

Reg. Dist. 01529

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>rural - Phoenix</i>		c. LENGTH OF STAY IN 1b <i>16 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SARAH</i>		d. STREET ADDRESS <i>Stensbury Mill Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Marguerite</i> First Middle <i>Clough</i> Last		4. DATE OF DEATH <i>7</i> Month <i>16</i> Day <i>1962</i> Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 23, 1900</i>
9. AGE (In years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Andrew Webster Jones</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Jane Stenner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Audrey Clough - Phoenix, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (c) <i>stroke</i> INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>years.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept</i> , 1950, to <i>Feb 16</i> , 1962, that I last saw the deceased alive on <i>Feb 16</i> , 1962, and that death occurred at <i>7 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Elizabeth B Sherrill</i>		ADDRESS (Street, city or town, state) <i>Cockeysville, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Elizabeth B Sherrill, MD</i>		DATE SIGNED <i>2/16/62</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb 20-1962</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Co. Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey Funeral Home</i>		ADDRESS <i>3631 Falls Road</i>	
24a. REC'D BY REGISTRAR <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	
DATE <i>FEB 19 '62</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01546

01530

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>1 year 9 mo.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		3. NAME OF DECEASED First <u>Grace</u> Middle <u>Patience</u> Last <u>COCHRAN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Sheppard & Enoch Pratt Hospital</u>		d. STREET ADDRESS <u>Homewood Apts., Balto 18, Md.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <u>February</u> Day <u>22</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8. 1873.</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Amos</u>		14. MOTHER'S MAIDEN NAME <u>Laura J. Amos (Maiden name unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Heart Failure</u> <u>481X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Influenza, incipient pneumonia, face</u> Contusion (c) <u>Generalized Arteriosclerosis</u> 48 hours Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome - Cerebral Arteriosclerosis - Psychotic Reaction.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidental fall while delirious during febrile illness</u>	
20c. TIME OF INJURY Month <u>22</u> Day <u>62</u> Year <u>19</u> Hour <u>7</u> a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) (County) (State) <u>Towson Baltimore Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>November 11, 1960</u> to <u>February 22, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb. 22, 1962</u> , and that death occurred at <u>5:20</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Harry M. Murdock</u>		22b. DATE SIGNED <u>February 22, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harry M. Murdock, M.D.</u>		22d. ADDRESS <u>The Sheppard & Enoch Pratt Hosp., Towson 4, Md.</u>	
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL (Specify) <u>2-24-62</u>		23b. DATE THEREOF <u>2-24-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GREEN Mount Crematory - Baltimore Md.</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. McKew & Son</u>		25a. REC'D BY REGISTRAR <u>26 '62</u>	
ADDRESS <u>Baltimore, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Robert S. Thomas</u>	

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RECEIVED - BUREAU OF THE ARMY

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01547

CERTIFICATE OF DEATH

01531

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Stevenson, Md.</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Stevenson, Md.</u>		d. STREET ADDRESS <u>Halcyon Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Halcyon Rd., Stevenson, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>Frank</u> Last <u>Cockey</u>		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1904</u>
9. AGE (In years lost birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucking</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George D. Cockey</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Parks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-20-3018</u>	
17. INFORMANT <u>Stevenson, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTILLATORY INSUFFICIENCY</u> DUE TO (b) <u>AMYOTROPHIC LATERAL SCLEROSIS</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardiovascular disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>December 1961</u> to <u>February 12 1962</u> , that (I) (not) last saw the deceased alive on <u>Feb. 12 1962</u> and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Carlton L. Sexton</u>		22b. DATE SIGNED <u>Feb. 13, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Carlton L. Sexton, M.D.</u>		22d. ADDRESS <u>819 Park Ave., Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 15, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Howell, Pikesville, Md.</u>		25a. REC'D BY REGISTRAR <u>Feb 15 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Carlton L. Sexton</u>		25c. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

01231

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 9/6D

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore																																			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sparrows Point												c. LENGTH OF STAY IN 1b 32 years																																			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 916 H Street												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																			
3. NAME OF DECEASED (Type or print) WILLIAM JOHN COHILL, Sr.												4. DATE OF DEATH February 4th, 1962																																			
5. SEX male				6. COLOR OR RACE white				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH June 28, 1898				9. AGE (In years last birthday) 63 yrs.				IF UNDER 1 YEAR Months Days				IF UNDER 24 HRS. Hours Min.																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Provider												10b. KIND OF BUSINESS OR INDUSTRY Steel												11. BIRTHPLACE (State or foreign country) Pennsylvania												12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Michael Cohill												14. MOTHER'S MAIDEN NAME Hanna Donvin																																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWI												16. SOCIAL SECURITY NO. 213-07-4217												17. INFORMANT Helen H. Cohill												Address same as #2											
18. CAUSE OF DEATH (Enter only one cause prevailing for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Hypertension C-V-Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)																								INTERVAL BETWEEN ONSET AND DEATH																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None																																			
20c. TIME OF INJURY Hour e.m. p.m. 19												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>												20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED 2/5/62																							
ACTUAL SIGNATURE Melvin B. Davis												M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																																			
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.												DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Dundalk 22, Maryland																																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial												22b. DATE THEREOF 2/7/62												22c. NAME OF CEMETERY OR CREMATORY Baltimore National												22d. LOCATION (City, town, or country) (State) Baltimore, Maryland											
23. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk 22, Md.												ADDRESS												24a. REC'D BY REGISTRAR FEB 6 '62												24b. REGISTRAR'S SIGNATURE Robert L. Harris											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01549 CERTIFICATE OF DEATH 01533

1. PLACE OF DEATH e. COUNTY <u>Balto.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Raspoburg</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Raspoburg</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7901 Comes Ave</u>			d. STREET ADDRESS <u>7901 Comes Ave</u>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Comes</u>			4. DATE OF DEATH Month <u>2</u> Day <u>-</u> Year <u>8</u> 19 <u>62</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11 1880</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>8</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Balto Co. Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Thomas Comes</u>			14. MOTHER'S MAIDEN NAME <u>Mary Rohr</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215 408701</u>		
17. INFORMANT <u>Mary M. Comes</u>			Address <u>7901 Comes Ave</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>190.9</u> DUE TO <u>Toxic Absorption</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Melanoma</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <u>e.m.</u> Month, Day, Year <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>November 1960</u> to <u>February 8, 1962</u> , that (I) (we) last saw the deceased alive on <u>6 February 1962</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Michael J. Dausch</u>			22b. DATE SIGNED <u>2-8-62</u>		
22c. PHYSICIAN'S NAME (Type) <u>Michael J. DAUSCH, M.D.</u>			22d. ADDRESS <u>4636 Belair Road</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-12-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemm</u>	
23d. LOCATION (City, town or county) <u>Fullerton Md</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Dippel Bros.</u>			ADDRESS <u>7110 Belair Rd.</u>		
25a. REC'D BY REGISTRAR <u>FEB 13 '62</u>			25b. REGISTRAR'S SIGNATURE <u>Charles S. Thoma</u>		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSMC
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01534

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bengies Md.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bengies</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>Box 3000 Bengies Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bengies Road Box 3000</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Louise</u> Last <u>Coupling</u>		4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 22, 1908</u>
9. AGE (In years last birthday) <u>53 1/2</u> yrs.		10. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bengies Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Bengies Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bradley Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Preston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>William Coupling Box 3000 Bengies Road</u>	
17. INFORMANT <u>William Coupling</u>		Address <u>Box 3000 Bengies Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive</u> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Conditio Vascular Disease</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> DUE TO (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Hour <u>0</u> e.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Se-lar - Boro com</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 10/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sharp Street Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Eastern Ave Chase Md.</u>
23. FUNERAL DIRECTOR <u>Milton E. Ellickson</u>		24a. REC'D BY REGISTRAR <u>1129 N. Caroline St</u>	
		24b. REGISTRAR'S SIGNATURE <u>Anthony S. Kraus</u>	

MEDICAL CERTIFICATION

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01551

01535

1. PLACE OF DEATH a. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md.			b. COUNTY Balto.		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 4 yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 221 Beaumont Ave			d. STREET ADDRESS 221 Beaumont Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ralph N. Crawford			4. DATE OF DEATH Feb. 28, 1962			5. SEX M.		
6. COLOR OR RACE W.			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Apr. 1, 1888		
9. AGE (In years last birthday) 73			10. IF UNDER 1 YEAR Months Days			11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Kelly Pontiac			11. BIRTHPLACE (County & State, or foreign country) Md.		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Ralph L. Crawford			14. MOTHER'S MAIDEN NAME Virginia Moore		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO. 218-03-0095			17. INFORMANT Mrs Edna Crawford, 221 Beaumont Ave, Catonsville 28, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Acute Coronary Occlusion Coronary Artery Disease INTERVAL BETWEEN ONSET AND DEATH 4 hrs 6 months			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) Catonsville			20g. (County) Catonsville			20h. (State) Md.		
21. I certify that (I) (this hospital) attended the deceased from 8-19-61 to Feb. 28, 1962, that (I) (we) last saw the deceased alive on Feb. 4, 1962, and that death occurred at 2:40 P.M. from the causes and on the date stated above.								
22a. SIGNATURE J. Nelson McKay			M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) J. Nelson McKay 6014 Edmondson Ave Catonsville 28, Md.			22d. ADDRESS 6014 Edmondson Ave, 28 Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/3/62			23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemty.		
23d. LOCATION (City, town or county) Pikesville Md.			23e. (State) Md.			23f. (County) Catonsville		
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.			ADDRESS 4101 Edmondson Ave.			25a. REC'D BY REGISTRAR DATE MAR 6 '62		
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus								

01232

01232

(M)

321 Beacon Ave
Jaco-ville
Jaco-ville

Ralph L. Crawford
W. M. Crawford
Apr. 1, 1968

Kelly E. Crawford
W. M. Crawford
Virginia Moore

215-03-0035
321 Beacon Ave, Jacksonville, FL, 32205

Handwritten notes:
Crawford Kelly E.
Crawford Ralph L.

Handwritten signature:
W. M. Crawford

321 Beacon Ave
Jaco-ville
Jaco-ville

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01536 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01536

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH e. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Balto. 7		c. LENGTH OF STAY IN 1b 8 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6300 Liberty Rd.		d. STREET ADDRESS 6300 Liberty Rd.	
3. NAME OF DECEASED (Type or print) VIOLET MAY CRISWELL		4. DATE OF DEATH Feb 17 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 4 1904
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Balto.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrence Knight.		14. MOTHER'S MAIDEN NAME Lena ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give year or dates of service)		16. SOCIAL SECURITY NO. none.	
17. INFORMANT Edward R Criswell - Same.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cerebral Hemorrhage 443X DUE TO Hypertensive C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days. 6 mos ?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. CAPLES		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-20-1962	
22c. NAME OF CEMETERY OR CREMATORY Woodland Memorial		22d. LOCATION (City, town, or country) (State) Balto. Md.	
23. FUNERAL DIRECTOR Loring Byers		24a. REC'D BY REGISTRAR FEB 21 '62	
ADDRESS 8728 Liberty Rd. Randallstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

01236



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01553

01537

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN <u>MARYLAND</u> <u>25 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Old Hanover Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> d. STREET ADDRESS <u>Old Hanover Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Linwood</u> Middle <u>Morgan</u> Last <u>Cross</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>1962</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 26, 1883</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker at School</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Valentine Cross</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Howard</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-32-1389</u>				17. INFORMANT <u>Mrs. Gertrude Cross, Reisterstown, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction - chronic - Decompen-</u> <u>260X</u> DUE TO <u>Hyper tension - ortherosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Diabetes -</u> DUE TO <u>Diabetes -</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (e) <u>Diabetes - severe - hard to control</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u> <u>30 yrs</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>											
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>					
21. I certify that (I) (this hospital) attended the deceased from <u>1-35-58</u> to <u>2-1-62</u> , that (I) (we) last saw the deceased alive on <u>2-17-62</u> , and that death occurred <u>8:30</u> PM, from the causes and on the date stated above.															
22a. SIGNATURE <u>James G. Saffell</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>2-4-62</u>							
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell</u>				22d. ADDRESS <u>Reisterstown, Md</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 5, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove</u>				23d. LOCATION (City, town or county) <u>Baltimore County, Md.</u>							
24 FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline & Sons, Reisterstown, Md.</u>				ADDRESS <u> </u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 5 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

01223

CERTIFICATE OF DEATH

01223



[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
15M 7/61

01554

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01538

Item 8 Film G306 2/7/62 iwk

1. PLACE OF DEATH a. COUNTY <u>BALTO -</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u> c. LENGTH OF STAY IN 1b <u>50YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>206 Church Lane</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u> d. STREET ADDRESS <u>206 Church Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>LOUISE</u> Last <u>CRUSEY</u>		4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1880</u> <u>10-28-1880</u>
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>8</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (County & State, or Foreign Country) <u>BALTO. Co. Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John S. Rodgers</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret C. Fryfoyle</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs Edith F. Rodgers - 206 Church Lane</u> Address <u>206 Church Lane</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio - sclerotic heart disease</u> <u>290.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>anemia (Hypo - chronic macrocytic)</u> (c) <u>general arterio - sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>12 yrs</u> <u>10 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 5, 1936</u> to <u>Feb 3, 1962</u> , that (I) <u>last</u> saw the deceased alive on <u>Feb 3, 1962</u> and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Palmer F.C. Williams</u> M.D.		22b. DATE SIGNED <u>Feb 3, 1962</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Ownip Mills, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2-6-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Ridge</u>	23d. LOCATION (City, town or county) (State) <u>md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		25a. REC'D BY REGISTRAR <u>Pikesville Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Harris</u>		DATE <u>FEB 5 '62</u>	

13

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01555

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01539

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Woodbrook (Baltimore-12) c. LENGTH OF STAY IN 1b 50 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) (Died at his residence)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Woodbrook (Baltimore-12) d. STREET ADDRESS 6201 Haddon Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Wiley Cushing		4. DATE OF DEATH February-11-62 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Abt-Aug-1888 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Baltimore City	
13. FATHER'S NAME Wiley Edmunds Cushing		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes WW-1		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. H.P. Stone (friend)		Address 6201 Haddon Av.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Coronary Thrombosis DUE TO Sudden		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/12/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) entombment		22b. DATE THEREOF Feb-14-62	
22c. NAME OF CEMETERY OR CREMATORY GreenMount		22d. LOCATION (City, town, or country) (State) Baltimore 2, Md.	
23. FUNERAL DIRECTOR Stewart & Mowen Co. 108-W-North-Av. Balto. 1, Md.		24a. REC'D BY REGISTRAR FEB 13 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

01553

MARKLAND STATE OF MICHIGAN DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1955

FILE NO.
100-2148



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01556
01540
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY -			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 82 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 106 112 S. Carlton St.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE R. DAHL				4. DATE OF DEATH February 24 1962		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH May 31, 1907				9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Alexander Dahl				14. MOTHER'S MAIDEN NAME Margaret Dorsey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW 11				16. SOCIAL SECURITY NO. 213-100561			
17. INFORMANT Clinical Records, VAH Baltimore 18 Maryland. FORT HOWARD DIVISION				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC BONE MARROW CARCINOMA DUE TO (c) Osteoarthritis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Osteoarthritis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Dec. 4 1961 to Feb. 24 1962 that (X) (we) last saw the deceased alive on Feb. 24 1962 , and that death occurred at 6:10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Antonio A. Bulls, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/25/62	
22c. PHYSICIAN'S NAME (Type) ANTONIO A. BULLS, M.D.				22d. ADDRESS VAH Balto 18, Md. Fort Howard Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-28-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan				ADDRESS Hollins & Poppleton Sts. Baltimore, Md.		25a. REC'D BY REGISTRAR FEB 28 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Kenna							

01510

01558



21510001

5-28-65

COMM. UNITED STATES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01557
01541

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 5yrlmth22dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville, Maryland d. STREET ADDRESS none e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Lula Middle Todd Last Davis			4. DATE OF DEATH Month February Day 9 Year 19 62		
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec. 14, 1878		9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 8 Days 2	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (County & State, or foreign country) Maryland	
14. FATHER'S NAME Alonzo R. Todd		15. MOTHER'S MAIDEN NAME unknown		16. CITIZEN OF WHAT COUNTRY? U. S. A.	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO. none		19. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Generalized arteriosclerosis, severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (X) (this hospital) attended the deceased from Dec. 17, 1956 to Feb. 9, 1962 that (X) (we) last saw the deceased alive on Feb. 9, 1962 , and that death occurred at 5 P. M, from the causes and on the date stated above.					
22a. SIGNATURE Loretta Hsu		22b. DATE SIGNED 2-9-62		22c. PHYSICIAN'S NAME (Type) Loretta Hsu, M. D.	
22d. ADDRESS SPRING GROVE STATE HOSPITAL		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ADDRESS Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/17/62		23c. NAME OF CEMETERY OR CREMATORY All Faith Cemetery	
23d. LOCATION (City, town or county) Charlotte Hall, Md.		(State)		23e. REC'D BY REGISTRAR P.B. Robinson	
23f. REGISTRAR'S SIGNATURE P.B. Robinson		23g. DATE FEB 19 '62		23h. REGISTRAR'S SIGNATURE William S. Thomas	

11610

01557

M

1. Robinson - Leonardson, M.
2. Robinson - Leonardson, M.
3. Robinson - Leonardson, M.
4. Robinson - Leonardson, M.
5. Robinson - Leonardson, M.
6. Robinson - Leonardson, M.
7. Robinson - Leonardson, M.
8. Robinson - Leonardson, M.
9. Robinson - Leonardson, M.
10. Robinson - Leonardson, M.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 18 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 N. Beechwood Avenue				d. STREET ADDRESS 8 N. Beechwood Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMMA Middle RUHL Last DEERING			4. DATE OF DEATH Month February Day 12 Year 19 62						
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1889		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Dr. Frank A. Ruhl				14. MOTHER'S MAIDEN NAME Emma Miller					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Charles Dukehart 8 N. Beechwood Avenue		Catonsville - 28, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac arrhythmia DUE TO (c) Myocardial Degeneration								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1956 to 12 Feb. 1962 that (I) was lost saw the deceased alive on 12 Feb. 1962 and that death occurred at 12 PM from the causes and on the date stated above.									
22a. SIGNATURE William J. Bryson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 13 Feb 62			
22c. PHYSICIAN'S NAME (Type) William J. Bryson				22d. ADDRESS 4605 Edmondson Ave., Baltimore 29 Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/15/1962		23c. NAME OF CEMETERY OR CREMATORY London Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home				ADDRESS Catonsville, Md.		25a. REC'D BY REGISTRAR DATE EB 15 '62		25b. REGISTRAR'S SIGNATURE C. S. Hanna	

01242

CERTIFICATE OF DEATH

01252



Baltimore

Maryland

Baltimore

Catonville

18 months

Catonville

X

8 N. Beechwood Avenue

8 N. Beechwood Avenue

62

February 12,

DEATH RECORD

75

April 7, 1889

X

White

Female

U. S. A.

Maryland

Own home

House wife

James Miller

Dr. Frank A. Miller

Catonville - 28, Md.

Mrs Charles Debeart 8 N. Beechwood Avenue

Home

No

Baltimore, Md.

London Park Cemetery

2/25/90

Final

Catonville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01559

CERTIFICATE OF DEATH

Reg. Dist. No.

01543

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 306 Mace Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle Dohler Last Dohler		4. DATE OF DEATH Month 2 Day 26 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-25-1866
9. AGE (In years last birthday) 95 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (State or foreign country) Baltimore County
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Andrew Dohler	
14. MOTHER'S MAIDEN NAME Margaret Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Fredrick Dohler Address 306 Mace Ave. (21)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure DUE TO Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO arterio-sclerotic cardiovascular disease (c) Several years			INTERVAL BETWEEN ONSET AND DEATH 2 days 10 days Several years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/16 , 19 62 , to 2/25 , 19 62 , that I last saw the deceased alive on 2/25 , 19 62 , and that death occurred at 11:40 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene C. Baumann M.D.		ADDRESS (Street, city or town, state) 413 EASTERN AVE, BALTO 21 DATE SIGNED 2-27-62	
PHYSICIAN'S NAME (Type) EUGENE C. BAUMANN		Ind.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-1-1962	
22c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lessahn Funeral Home		ADDRESS 7401 Belair Road	
24a. REC'D BY REGISTRAR MAR 2 '62		24b. REGISTRAR'S SIGNATURE Arthur J. Home	

CERTIFICATE OF DEATH

1920

Decd.

Place of Birth

Age

Sex

Color

Marital Status

Occupation

Education

Religion

Place of Death

Cause of Death

Manner of Death

Time of Death

Place of Burial

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of Town Clerk

Signature of Notary Public

Signature of Justice of the Peace

Signature of Sheriff

Signature of Constable

Signature of School Committee

Signature of Board of Health

Signature of Board of Selectmen

Signature of Board of Supervisors

Signature of Board of Aldermen

Signature of Board of Deacons

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01560

CERTIFICATE OF DEATH

01544

Item 9 Film G308

3/5/62 iwk

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b 4yr5mth15dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Maryland d. STREET ADDRESS unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Emma Last Donath		4. DATE OF DEATH FEB 23 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1874
9. AGE (In years last birthday) 88 1/2 yrs.	IF UNDER 1 YEAR Months 16 Days 8	IF UNDER 24 HRS. Hours 23 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John A. Ulle		14. MOTHER'S MAIDEN NAME Maegaret unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacteremia, unspecified DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extensive abscess of right arm, unspecified DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Brian Syndrome associated with cerebral arteriosclerosis Degenerative joint disease, multiple, due to unknown cause			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (County) (State) 21. I certify that (X) (this hospital) attended the deceased from Aug. 20, 1957 to Feb., 23, 1962 , that (I) (we) last saw the deceased alive on Feb., 23, 1962 , and that death occurred at 11:00 PM from the causes and on the date stated above. 22a. SIGNATURE Jose R. Arizaga M.D. Fe., 24, 1962 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) Jose R. Arizaga, M.D. 22d. ADDRESS SPRING GROVE STATE HOSPITAL CATONSVILLE 28, Maryland 23a. BURIAL, CREMATION, REMOVAL (Specify) 2/28/62 23b. DATE THEREOF Cedar Hill 23c. NAME OF CEMETERY OR CREMATORY Swilland md 23d. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home ADDRESS 300 - 4 ST NE 25a. REC'D BY REGISTRAR FEB 28 '62 25b. REGISTRAR'S SIGNATURE Carlton E. Thomas			

01514

01580



John F. O'Grady

*The Federal Home
300 - 4 24/E
2/28/12 Cedar Hill
Baltimore Md*

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01561		Item 9 Film 0308 3/9/62 mh		01545	
1. PLACE OF DEATH e. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY in lb 26yr1mth2dys		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 4001 Cottage Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise		Middle (Dubbs)		Last Dub	
4. DATE OF DEATH Month February		Day 26		Year 19 62	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH May 24, 1892		9. AGE (In years last birthday) 69 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (County & State, or foreign country) Germany	
14. FATHER'S NAME unknown		15. MOTHER'S MAIDEN NAME unknown		16. CITIZEN OF WHAT COUNTRY? Germany	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown		18. SOCIAL SECURITY NO. unknown		19. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
20. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420 ✓ DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease (c) DUE TO		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus		22. INTERVAL BETWEEN ONSET AND DEATH	
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		25. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
26. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		27. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
29. (City or town)		30. (County)		31. (State)	
21. I certify that (this hospital) attended the deceased from Oct. 24, 1935, to Feb. 26, 1962, that (I) last saw the deceased alive on Feb. 26, 1962, and that death occurred at 4:00 P.M. from the causes and on the date stated above.					
22. SIGNATURE Stella Wachler		23. ATTENDING PHYS. M.D. 24. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md.		25. DATE SIGNED 2-26-62	
26. PHYSICIAN'S NAME (Type) Stella Wachler, M. D.		27. BURIAL, CREMATION, REMOVAL (Specify) Burial		28. DATE THEREOF 3/1/62	
29. NAME OF CEMETERY OR CREMATORY New Cathedral		30. LOCATION (City, town or county) Old Frederick Rd. Md.		31. (State)	
32. FUNERAL DIRECTOR'S SIGNATURE Krause Funeral Home		33. ADDRESS 1216 S. Charles St.		34. REC'D BY REGISTRAR DATE MAR 5 '62	
35. REGISTRAR'S SIGNATURE Arthur L. Krause		36. REGISTRAR'S SIGNATURE		37. REGISTRAR'S SIGNATURE	

01512

1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01562

CERTIFICATE OF DEATH

01546

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY in lb 14 mos 28 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Grove Sta te Hospita l		d. STREET ADDRESS 100 Georgia Ave	
3. NAME OF DECEASED (Type or print) First Viola Middle -- Last DUNN		4. DATE OF DEATH Month Feb. Day 25 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-89
9. AGE (In years and months) 72 yrs.		IF UNDER 1 YEAR Months 2 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Hodges		14. MOTHER'S MAIDEN NAME Elizabeth Peed	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Pts. Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 422 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerotic Cardiovascular Disease (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) --	
20c. TIME OF INJURY Month, Day, Year Hour a.m. -- p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-28 1962 to 2-25 1962 , that (I) (we) last saw the deceased alive on 2-25 1962 , and that death occurred at 7:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE Maurice J. Van Besien		22b. DATE SIGNED 2/25/62	
22c. PHYSICIAN'S NAME (Type) MAURICE J. VAN BESIE		22d. ADDRESS SPRING GROVE ST HOSP. BALT 28 MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-28-1962	23c. NAME OF CEMETERY OR CREMATORY Dublin Grove Cemetery	23d. LOCATION (City, town or county) (State) Royall, North Carolina
24. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA 7922 Wise Avenue 22, Md..		25. REC'D BY REGISTRAR 1 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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JOHN T. DUNN 704 West Avenue 22, 10.
BOSTON 2-40-2442

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **01547****01563**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison			c. LENGTH OF STAY IN 1b 17 mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Foxleigh Nursing Home				d. STREET ADDRESS 308 Pleasant Hill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anita Middle T. Last Easter				4. DATE OF DEATH Month 2 Day 11 Year 1962			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-1-1890		9. AGE (In years last birthday) yrs. 71	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Howard Tinges				14. MOTHER'S MAIDEN NAME Margaret Webster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --		17. INFORMANT James W. Easter		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis with hypertension DUE TO 3 3 1 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral hemorrhage at subdural level DUE TO 4 yrs (c) cerebral arterio-sclerosis, many small hemorrhages DUE TO 2 yrs INTERVAL BETWEEN ONSET AND DEATH 5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 8, 1945 to Feb 11, 1962 , that I last saw the deceased alive on Feb 11, 1962 , and that death occurred at 6:15 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Palmer F.C. Williams				ADDRESS (Street, city or town, state) Owings Mills, Md.		DATE SIGNED 2/12/62	
PHYSICIAN'S NAME (Type) PALMER F.C. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-14-62		22c. NAME OF CEMETERY OR CREMATORY St. Thomas'		22d. LOCATION (City, town, or county) (State) Garrison Forest Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd.		24a. REC'D BY REGISTRAR DATE FEB 15 '62	
				24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

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1. **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician and completely filled in by the funeral director. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01564

01548

1. PLACE OF DEATH e. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3425 Washington Blvd.		d. STREET ADDRESS 3425 Washington Blvd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Eichelman, Jr. Last 		4. DATE OF DEATH Month Feb. Day 24, Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1885
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Eichelman, Sr.		14. MOTHER'S MAIDEN NAME Mary Scharf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Daughter Regina Duraczynski, 3425 Washington Blvd. #27		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) 443X DUE TO Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Arteriosclerotic Hypertensive CVD (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH sudden 7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 12, 1961 to Feb. 24, 1962 that (I) (we) last saw the deceased alive on Jan 7, 1962 and that death occurred 6:45 AM from the causes and on the date stated above.			
22e. SIGNATURE Herbert J. Levickas		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Herbert J. Levickas, M. D.		22d. ADDRESS 5305 East Drive, Baltimore 27, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/27/62	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town or county) (State) Elkridge, Howard Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Avenue, #29		25a. REC'D BY REGISTRAR DATE FEB 26 '62	
25b. REGISTRAR'S SIGNATURE Charles L. Thomas			

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Anticardiac Hypertension CVD 7 yrs.
Cardiac hypertrophy

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May 15, 1963
Fitz 24 63

X

John J. Lewis
1963

Howard H. Hubbard, 4101 Wilkins Avenue, 422

Howard H. Hubbard, 4101 Wilkins Avenue, 422

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01565

01549

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 27 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5701 Chinquapin Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN GEORGE EIERMAN		4. DATE OF DEATH Month Day Year February 4, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1896
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personnel Manager		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Eierman		14. MOTHER'S MAIDEN NAME Katherine Dittmar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 215-10-3784	
17. INFORMANT Clin Rec VAH Baltimore Md - Ft Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIOSCLEROTIC CARDIOVASCULAR HEART DISEASE (c) DIABETES MELLITUS; BRONCHOPNEUMONIA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS; BRONCHOPNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 11 DAYS YEARS	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 8, 1962 to Feb. 4, 1962 that we last saw the deceased alive on Feb. 4, 1962 , and that death occurred at 2:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Merle J. Wampler, Jr. M.D.		22b. DATE SIGNED 2-4-62	
22c. PHYSICIAN'S NAME (Type) Merle J. Wampler, Jr.		22d. ADDRESS VAH Baltimore 18 Md - Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-7-62	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City, town or county) (State) Pikesville Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co., Inc. Baltimore Md		25a. REC'D BY REGISTRAR FEB 5 '62	
ADDRESS 4905 York Road		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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MAINTENANCE AND REPAIRS

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CHIEF ENGINEER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01567

01551

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>near Rockdale</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>(Benedict Home - Private)</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1023-N-Eutaw-Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>MAMIE</u> <u>RIDGELY</u> <u>EMBERT</u> First Middle Last				4. DATE OF DEATH <u>February-19-62</u> 19 Month Day Year											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July-6-1879</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Easton, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>William Gould</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Powell</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war/dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Robt. L. Grafflin (sister)</u> Address <u>1023-N-Eutaw-St. City</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420-1</u> IMMEDIATE CAUSE (e) <u>Coronary Occlusion</u> DUE TO (b) <u>Hypertensive C.V. disease - Atrial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Unsup.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 years</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>APR 1, 1959</u> , to <u>FEB 19, 1962</u> ; that (I) (we) last saw the deceased alive on <u>FEB 19, 1962</u> , and that death occurred at <u>730</u> AM, from the causes and on the date stated above.															
22a. SIGNATURE <u>Thomas E. Wheeler</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Thomas E. Wheeler</u>						22d. ADDRESS <u>Liberty and Clifmar Roads. Randallstown.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b. DATE THEREOF <u>Feb-21-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore 29, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart & Mowen Co., 108-W-North-Av. Balto. 1-Md.</u>						ADDRESS		25a. REC'D BY REGISTRAR <u>FEB 20 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>					

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Item I - June 2/20/62 a.s.

wa. 2-5573

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. 01552

01568

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 7mth25dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 10-D Parkway Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lucille Middle Anna Last Evans				4. DATE OF DEATH Month February Day 4 Year 19 62			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1893	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 6 Days 8 Hours 15 Min.		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Virginia, Portsmouth	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME xxxxxx Charles N. Humphreys				14. MOTHER'S MAIDEN NAME xxxxxx Lou Emma Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] unknown None				16. SOCIAL SECURITY NO. none		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 561.5 IMMEDIATE CAUSE (a) Strangulated hernia of small intestines DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic intestinal adhesions DUE TO (c) Chronic intestinal adhesions				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) SPRING GROVE STATE HOSPITAL				(County)		(State)	
21. I certify that I attended the deceased from June 9, 19 61 to Feb. 4, 19 62 , that I last saw the deceased alive on Feb. 4, 19 62 , and that death occurred at 2:10 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL			
DATE SIGNED 2-5-62							
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland			
22a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 7, 1962		22c. NAME OF CEMETERY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.				ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR DATE FEB 9 '62	
24b. REGISTRAR'S SIGNATURE							

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01569 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01553

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE 12		c. LENGTH OF STAY in 1b 15 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Stoneleigh			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 700 KINGSTON RD				d. STREET ADDRESS 1700 KINGSTON RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH LEON FAISANT				4. DATE OF DEATH FEB 4 1962			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-3-01	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSULT. ENGR.		10b. KIND OF BUSINESS OR INDUSTRY ENGR.		11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN S. FAISANT				14. MOTHER'S MAIDEN NAME SIEGERT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-05-6352		17. INFORMANT Address Joseph Faisant, Jr. - 131 Marburth Rd. - #4			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William A. Pillsbury		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-4-62	
EXAMINER'S NAME (Type) William A. Pillsbury		DEPUTY MEDICAL EXAMINER Timoniam		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-7-62	22c. NAME OF CEMETERY OR CREMATORY NEW Cathedral Cem.		22d. LOCATION (City, town, or country) BALTO, Md.		(State)	
23. FUNERAL DIRECTOR ADDRESS Wm. J. Ickner & Sons Balto. 12 Md				24a. REC'D BY REGISTRAR FEB 5 '62		24b. REGISTRAR'S SIGNATURE William S. Trana	

MEDICAL CERTIFICATION

01583

01583

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mth 6dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 5141 Westland Blvd.	
3. NAME OF DECEASED (Type or print) Adolf Otto Fielitz		4. DATE OF DEATH February 6, 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1877
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Hi. AUTH. PRORSAL CO. butcher	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Fielitz		14. MOTHER'S MAIDEN NAME Carolina Lucke	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) none		16. SOCIAL SECURITY NO. 578-05-2323	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary occlusion (e), stating the underlying cause last. (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic brain syndrome associated with arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 19 (this hospital) attended the deceased from Dec. 15, 1961 to Feb. 6, 1962 , that (I) (X) last saw the deceased alive on Feb. 6, 1962 , and that death occurred at 8:50 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE 2-6-62	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, or other disposition of body BURIAL		23b. DATE THEREOF 2/9/62	
23c. NAME OF CEMETERY OR CREMATORY LONDON PK. CEMT.		23d. LOCATION (City, town or county) (State) BALTO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE, 4101 EDMONDSON AVE.		25. REC'D BY REGISTRAR FEB 9 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

01221

01270

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND
CERTIFICATE OF DEATH

01571

01535

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 12 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 17 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3001-4 d. STREET ADDRESS 930 Brooks Lane (Apt. A-1) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS J. FISHER		4. DATE OF DEATH Month Day Year February 12 1962	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 25, 1897
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - farmer	
11. BIRTHPLACE (County & State, or foreign country) Greenwood Co., S. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Fisher		14. MOTHER'S MAIDEN NAME Sallie MN: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 578-14-2405	
17. INFORMANT Clinical Records, VAH, BALTO 18, MD., FT. HOWARD DIV.		18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) OBSTRUCTIVE EMPHYSEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerotic Heart Disease. Arteriosclerosis, Generalized.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> YES <input type="checkbox"/> NO	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore		20g. (County) Baltimore	
20h. (State) Maryland		21. I certify that (this hospital) attended the deceased from January 31 1962 to February 12 1962 , that (he) (we) last saw the deceased alive on February 12 1962 , and that death occurred at 7:45 A.M., from the causes and on the date stated above.	
22a. SIGNATURE Irving Freeman		22b. DATE SIGNED 2/12/62	
22c. PHYSICIAN'S NAME IRVING FREEMAN, M.D. Chief, Medical Service		22d. ADDRESS VAH, BALTO 18 MD FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-16-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Morton & Dyett Funeral Directors		25a. REC'D BY REGISTRAR FEB 15 '62	
25b. REGISTRAR'S SIGNATURE Carlton S. House			

M

11577

01555

RECEIVED
JAN 10 1955
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK (100-155555)
SUBJECT: [Illegible]
RE: [Illegible]

100-155555
[Illegible text block containing various lines of text, mostly mirrored or bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01572

CERTIFICATE OF DEATH

Item 1c Film G307 2/14/62 iwk

01556

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY -		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4113 Rondo Court - Brooklyn, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS as above		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Benjamin Middle H. Last Flynn			4. DATE OF DEATH Month February Day 6 Year 19 62		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1888	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 73 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) watchman		10b. KIND OF BUSINESS OR INDUSTRY Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Zacariah Flynn			14. MOTHER'S MAIDEN NAME Rose Smith		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown MN		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 27, 1962 to Feb. 6, 1962 , that (I) (we) last saw the deceased alive on Feb. 6, 1962 , and that death occurred at 1:30 p.m. from the causes and on the date stated above.					
22a. SIGNATURE Stella Wachslar M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 2-6-62		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/9/62		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.	
23d. LOCATION (City, town or county) Elkridge, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes		ADDRESS 130 E Fort Ave.		25a. REC'D BY REGISTRAR FEB 7 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. K...					

01252

01252



01252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01573

01557

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Eoseth</i> c. LENGTH OF STAY in lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>327 Ballard Ave.</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Eoseth</i> d. STREET ADDRESS <i>327 Ballard Ave.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>Sophia ANNA FOLTZ</i>				4. DATE OF DEATH Month <i>Feb</i> Day <i>16</i> Year <i>1962</i>											
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAY 16, 1900</i>		9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>16</i>		IF UNDER 24 HRS. Hours <i>16</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <i>Balto. Co. Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>John Hulcher</i>				14. MOTHER'S MAIDEN NAME <i>Mary Schmidt</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <i>Daniel (son) 9128 Lenning Lane.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Carcinoma of uterus</i> <i>174X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>INTERVAL BETWEEN ONSET AND DEATH 5 years</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1</i> 1962 to <i>Feb. 16</i> 1962 that (I) (we) last saw the deceased alive on <i>Feb. 15</i> 1962 and that death occurred at <i>12:30</i> PM, from the causes and on the date stated above.															
22a. SIGNATURE <i>J. M. Baumgardner</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>2/16/62</i>									
22c. PHYSICIAN'S NAME (Type) <i>Balto 6 Md</i>						22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>2-19-62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Morlands Memorial</i>				23d. LOCATION (City, town or county) (State) <i>Balto. Md.</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Connelly</i>						ADDRESS <i>418 Eastern Blvd.</i>				25. REC'D BY REGISTRAR <i>FEB 20 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Rimmer</i>			

01225

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(M)

(1)

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "John", "John", "John" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01574					01558					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY		Baltimore			a. STATE		Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Towson			b. COUNTY					
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Presbyterian Home			d. STREET ADDRESS		3559 4th St., Brooklyn			
e. IS RESIDENCE ON A FARM?					a. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First		Middle		Last		Month		Day Year		
Emma				Fontz		Feb. 17		19 62		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 31, 1878	84	Months Days	Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
None				Baltimore, Maryland		U.S.A.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
George F. Fontz					Margaret A. Watts					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No				Mrs. T.E. Elliott		Presbyterian Home				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)							8 mos			
157X DUE TO										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							(b)			
							(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED?			
Arteriosclerotic Cardiovascular Disease							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
21. I certify that (I) (Michael) attended the deceased from January 19 58 to Feb. 16 62, that (I) (we) last saw the deceased alive on Feb. 14, 19 62, and that death occurred at 6:25 am, from the causes and on the date stated above.										
22a. SIGNATURE							ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)							22d. ADDRESS			
S.J.Venable, Jr. M.D.							7215 York Road, Baltimore 12, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)				
Burial		2-20-62		Lorraine		Woodlawn, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John O. Mitchell & Sons, Inc. 1900 Eutaw Place						FEB 23 '62		Arthur S. Hume		

01228

01228

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01575		Item 8 Film G307 2/20/62 iwk				01559			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6 Burnbrae Road</u>					d. STREET ADDRESS <u>6 Burnbrae Rd.</u>				
3. NAME OF DECEASED (Type or print) <u>Katherine R. Forsythe</u>					4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1962</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1884</u> <u>October 9, 1884</u>		9. AGE (in years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John M. Lowry</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Coffey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Norman R. Dresbach</u>		Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>4-20-1</u> DUE TO <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u> </u> (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> <u>1962</u> to <u>2/10</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>2/5</u> <u>1962</u> , and that death occurred at <u>1:22</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>T.C. Siwinski</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Dr. Thaddeus C. Siwinski</u>					22d. ADDRESS <u>206 W. Penna. Ave. Towson, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL. (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-13-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Fred A. Cole</u>					ADDRESS <u>1913 W. Baltimore St.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 13 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Anthony S. Thomas</u>

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

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MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01576 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01560											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>901 Old Oak Road</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u> d. STREET ADDRESS <u>901 Old Oak Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Robert J. French</u>						4. DATE OF DEATH <u>February 17</u> 19 <u>62</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 29, 1892</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>New Amsterdam Casualty-Maryland Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? French</u>						14. MOTHER'S MAIDEN NAME <u>Mary Cooney</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. J.S. Moran-310 Dunkirk Road- Balto. Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4-20-61</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2/17/62</u>											
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>					
23. FUNERAL DIRECTOR <u>Wm J. Tucker & Sons</u> ADDRESS <u>Balto 17 Md.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 19 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

01500

MEDICAL EXAMINATION REPORT

NEW YORK
JULY 1951

(M)

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REPORT OF EXAMINATION

AND RECOMMENDATIONS

1. HISTORY

2. PHYSICAL

3. LABORATORY

4. X-RAY

5. PATHOLOGY

6. TREATMENT

7. PROGNOSIS

8. FOLLOW-UP

9. COMMENTS

10. SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01577

CERTIFICATE OF DEATH

01561

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland f. COUNTY Baltimore g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 22 h. STREET ADDRESS 7729 Stansbury Road i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JACOB --- GATLING		4. DATE OF DEATH February 3 1962	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1896
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (County & State, or foreign country) Suffolk, Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Thomas Gatling	
14. MOTHER'S MAIDEN NAME Mimia Kenney		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I	
16. SOCIAL SECURITY NO. 218-18-9819		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO 273X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) SEVERE ANEMIA DUE TO (c) UNKNOWN		19. INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 31 1962 to February 3, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 3 1962 , and that death occurred at 1:05 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John D. Talbert 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D. Medical Service		22b. DATE SIGNED 2/5/62 22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	22e. ATTENDING PHYS. <input type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input checked="" type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-8-62	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson, 1000 Brantley Ave., Balto 17, Md.		25. REC'D BY REGISTRAR FEB 14 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Hines

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01578

CERTIFICATE OF DEATH

01562

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b X	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		d. STREET ADDRESS 7406 Belmont Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7406 Belmont Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle GEORGE Last GEGNER.		4. DATE OF DEATH Month February Day 21 Year 1962.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 12, 1885
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Balto. Brick Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles H. Gegner		14. MOTHER'S MAIDEN NAME Caroline W. Rehmer.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-01-3502	
17. INFORMANT John A. Gegner: 7402 Belmont Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 3:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE B. M. OTEY		22b. DATE SIGNED Feb. 22/62	
22c. PHYSICIAN'S NAME (Type) BENIGNO M. OTEY		22d. ADDRESS 1628 Cathedral Street #1 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-24-62.	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town, or county) Balto., Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Jailer		25a. REC'D BY REGISTRAR FEB 26 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

11578

CHINA AIRLINE

01565



CERTIFICATE OF DEATH

Reg. Dist. No. **01563****01579**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6903 Ridgeway				d. STREET ADDRESS 6903 Ridgeway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle C. Last GEPHARDT		4. DATE OF DEATH Month February Day 9 Year 19 62		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 26, 1889		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Gephardt				14. MOTHER'S MAIDEN NAME Eva Rosina Pfarr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Ralph Crawford, 6903 Ridgeway, Balto. 22, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HEART FAILURE DUE TO (b) METASTATIC CARCINOMA DUE TO (c) CARCINOMA OF COLON Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 3 mos 6 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY , 19 61 , to FEB 9 , 19 62 , that I last saw the deceased alive on FEB 8 , 19 62 , and that death occurred at 3⁰⁰ PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7538 HOLABIRD AVE DATE SIGNED							
ACTUAL SIGNATURE Leonard M. Zullo M.D.		PHYSICIAN'S NAME (Type) LEONARD M. ZULLO BALTO. 22, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Feb. 13, 1962		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Cnty., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, Dundalk, Md.				24a. REC'D BY REGISTRAR FEB 13 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Thoma	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01821

UNITED STATES OF AMERICA

2525



01580

CERTIFICATE OF DEATH

Reg. Dist. No 01564

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8310 Bon Air Rd.		d. STREET ADDRESS 8310 Bon Air Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CORA Middle ELLEN Last GESSFORD		4. DATE OF DEATH Month February Day 12 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1872
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel E. Yerby		14. MOTHER'S MAIDEN NAME Ida Louise Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT Miss Virginia Stewart 8310 Bon Air Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1962 to Feb 12, 1962 that I last saw the deceased alive on Feb 11, 1962 and that death occurred at 10³⁰ PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph F. Hibern		ADDRESS (Street, city or town, state) 8400 Loch Haven Blvd	
PHYSICIAN'S NAME (Type) JOSEPH F. HIBERN		DATE SIGNED 2/13/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-15-62	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		ADDRESS 4210 Belair Rd. 6	
24a. REC'D BY REGISTRAR DATE FEB 19 '62		24b. REGISTRAR'S SIGNATURE Orlando L. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01581

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CERTIFICATE OF DEATH 3/23/62 iwk

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1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12X-2 UNION BRIDGE unknown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS HORTON'S NURSING HOME ROUTE 1	
3. NAME OF DECEASED (Type or print) First ADA Middle H. Last GIBSON		4. DATE OF DEATH Month FEB Day 25 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-31-1984
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) BEL AIR MD.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME SAMUEL GIBSON		14. MOTHER'S MAIDEN NAME PRISCILLA HOPKINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. PTS RECORDS.	
17. INFORMANT PTS RECORDS.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-20-1962 to 2-25-1962 that (I) (we) last saw the deceased alive on 2-24-1962 and that death occurred at 7:34 AM , from the causes and on the date stated above.			
22a. SIGNATURE Maurice J. Van Besien M.D.		22b. DATE 2/25/62	
22c. PHYSICIAN'S NAME (Type) MAURICE J. VAN BESIEV		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/12/62	
23c. NAME OF CEMETERY OR CREMATORY Anatomy Board - Medical School - University of Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Spring Grove State Hospital transported body.		25a. REC'D BY REGISTRAR DATE FEB 28 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01582
CERTIFICATE OF DEATH
01566

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House in the Pines Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 548 Brook Road #4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Winfield Ardin Goss		4. DATE OF DEATH February 26 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1877
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Bldg. Supt.		10b. KIND OF BUSINESS OR INDUSTRY Kyser Bldg.	9. AGE (In years last birthday) 84 yrs.
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? Gross		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 216-01-8006	
17. INFORMANT Mrs. John H. Lampe		Address 548 Brook Road- Towson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stokes-Adam Syndrome 433.0 DUE TO Cerebral Arteriosclerosis severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1958 to Feb 26, 1962 , that (I) (we) last saw the deceased alive on Feb 26, 1962 , and that death occurred at 4:10 PM , from the causes and on the date stated above.			
22a. SIGNATURE M Paul Byerly M.D.		22b. DATE SIGNED 5820 York Rd Balto	
22c. PHYSICIAN'S NAME (Type) M Paul Byerly		22d. ADDRESS 5820 York Rd Balto	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-28-62	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tucker & Sons Balto 12, Md.		25a. REC'D BY REGISTRAR FEB 27 '62	
25b. REGISTRAR'S SIGNATURE Wm J. Tucker			

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Handwritten signature or text at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01583
CERTIFICATE OF DEATH
01567

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY in 1b <u>53 yrs</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>128 PARKIN ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNA GRAJAUSKAS, GRAY - GRAEVSKY</u> First Middle Last 4. DATE OF DEATH <u>FEBRUARY 10 1962</u> Month Day Year				5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-15-1881</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u> 11. BIRTHPLACE (County & State, or foreign country) <u>LITHUANIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u> </u> 14. MOTHER'S MAIDEN NAME <u> </u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>220-12-5580</u> 17. INFORMANT <u>THOMAS G. GRAY</u> Address <u>600 CHARING CROSS RD.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis Cerebral</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1 1962</u> to <u>Feb 10 1962</u> , that (I) (we) last saw the deceased alive on <u>2/10/1962</u> and that death occurred <u>2/10/1962</u> at <u>4:47</u> P.M. from the causes and on the date stated above.				22a. SIGNATURE <u>E J Mendelis</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2/13/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>E J Mendelis</u> 22d. ADDRESS <u>651 N Bentallou</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2-14-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>MOST HOLY REDEEMER</u> 23d. LOCATION (City, town or county) (State) <u>MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Archauskas</u> ADDRESS <u>637 Washington</u> 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur E. Krasa</u> DATE <u>FEB 15 '62</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician, and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01584

01568

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 28 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore 17 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1528 McCulloh Street d. STREET ADDRESS 3401-4	
3. NAME OF DECEASED (Type or print) JAMES -- GREEN		4. DATE OF DEATH February 16 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1892
9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		11b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (County & State, or foreign country) Jacksonville, Florida		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Green		14. MOTHER'S MAIDEN NAME Hattie MN: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-01-5847	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		Address Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA, SIGMOID COLON, WITH METASTASIS XXXX TO BLADDER, LIVER, PELVIC FOSSA AND PERITONEUM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UNKNOWN DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PERITONITIS- Duration Few Days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from January 19, 1962 to February 16, 1962 , that (we) last saw the deceased alive on February 16, 1962 , and that death occurred at 9:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE S. Russo		22b. DATE 2/16/62	
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.		22d. ADDRESS VAH, BALTIMORE 18 MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-20-63	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE S. Sullivan		25a. REC'D BY REGISTRAR FEB 20 '62	
25b. REGISTRAR'S SIGNATURE S. Sullivan		25c. ADDRESS Baltimore, Maryland	

VR A15 (4)
15M 9/60

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1. General Information

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01585

01589

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Randallstown</u> c. LENGTH OF STAY in 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Randallstown</u> d. STREET ADDRESS <u>Allen Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Walter E. Green</u> First Middle Last				4. DATE OF DEATH <u>Feb 11 1962</u> Month Day Year											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 16, 1898</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John H. Green</u>				14. MOTHER'S MAIDEN NAME <u>Anna Lupton</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>220-07-4176</u>				17. INFORMANT <u>Mrs Ethel Green - Randallstown, Md.</u> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>10/1/1961</u> , 1961 , to <u>2/10/1962</u> , 1962 , that (I) (we) last saw the deceased alive on <u>2/9/1962</u> , 1962 , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above,															
22a. SIGNATURE <u>Wm. E. Martin</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Wm. E. Martin</u>						22d. ADDRESS <u>Randallstown, Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-14-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woods Chapel</u>				23d. LOCATION (City, town, or county) (State) <u>Liberty Road - Balt Co., Md</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Haight</u> <u>Lyckville, Md.</u> ADDRESS						25a. REC'D BY REGISTRAR <u>FEB 15 '62</u> DATE				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01586

CERTIFICATE OF DEATH

Reg. Dist. No. 01570

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - 74		c. LENGTH OF STAY IN 1b 5 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7231 Bridgewood Drive		d. STREET ADDRESS 7231 Bridgewood Drive	
3. NAME OF DECEASED (Type or print) CARMELA M GRELLI		4. DATE OF DEATH FEB. 7 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY, 11 1892
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY ITALY	
11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? ITALY	
13. FATHER'S NAME Antonio PAPA		14. MOTHER'S MAIDEN NAME Stella MARSIGLIA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NO NONE	
17. INFORMANT BONOLIS, SANTINA		Address 8018 WYNBROOK RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastases DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/19/1961 to 2/7/62 , that I last saw the deceased alive on 2/7/62 , 19____, and that death occurred at 2:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE W. E. Baermann M.D.			
PHYSICIAN'S NAME (Type) W. E. BAERMANN, M. D. 3401 DUNDALK AVE., BALTIMORE 22			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Feb. 10 1962	
22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		22d. LOCATION (City, town, or county) (State) BALTO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Deller		24a. REC'D BY REGISTRAR FEB 13 1962	
24b. REGISTRAR'S SIGNATURE Frank Deller		24c. REGISTRAR'S SIGNATURE Frank Deller	

CERTIFICATE OF DEATH

293

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1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. COLOR [Illegible]		9. RELIGION [Illegible]		10. EDUCATION [Illegible]		11. SOCIAL CLASS [Illegible]		12. PLACE OF DEATH [Illegible]	
13. DATE OF DEATH [Illegible]		14. TIME OF DEATH [Illegible]		15. CAUSE OF DEATH [Illegible]		16. MANNER OF DEATH [Illegible]		17. PLACE OF INTERMENT [Illegible]		18. SIGNATURE OF REGISTRAR [Illegible]	
19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF WITNESS [Illegible]		21. SIGNATURE OF PHYSICIAN [Illegible]		22. SIGNATURE OF CLERGYMAN [Illegible]		23. SIGNATURE OF FUNERAL HOME [Illegible]		24. SIGNATURE OF BURIAL SOCIETY [Illegible]	

RECEIVED BY THE STATE DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND
[Illegible text]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01587
CERTIFICATE OF DEATH
01571

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>416 Hillen Road</u>				d. STREET ADDRESS <u>416 Hillen Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry G. Grolock</u>				4. DATE OF DEATH Month Day Year <u>Feb. 18 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-27-1884</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Pipe Fitter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Gustav C. Grolock</u>				14. MOTHER'S MAIDEN NAME <u>Augusta Discher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Paul Grolock</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>42202</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 17, 1962</u> to <u>Feb. 17, 1962</u> ; that (I) (we) last saw the deceased alive on <u>Feb. 17, 1962</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. J. Schmitz</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wm. J. Schmitz</u>				22d. ADDRESS <u>701 N. Kennerd Ave. Park Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>2-21-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc. 5305 Harford Rd.</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>FEB 20 '62</u>	
						25b. REGISTRAR'S SIGNATURE <u>Clifford E. Finner</u>	

15210

78520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01588

CERTIFICATE OF DEATH

01572

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay		c. LENGTH OF STAY IN 1b 65 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Relay Hill Hospital (her home she was partnership)		d. STREET ADDRESS Viaduct avenue	
3. NAME OF DECEASED (Type or print) Sadie Perkins Gundry		4. DATE OF DEATH Feb. 3, 1962	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1871
9. AGE (In years last birthday) 91		IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (K)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore Co.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard K. Perkins		14. MOTHER'S MAIDEN NAME Amanda M. Pierce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-40-11430	
17. INFORMANT Son: Dr. Lewis P. Gundry, Relay 27, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 4 50.0 DUE TO Arteriosclerotic vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 18 days Many years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 10, 1956, to Feb. 3, 1962, that (I) (we) last saw the deceased alive on Feb. 3, 1962, and that death occurred at A. M., from the causes and on the date stated above.		22a. SIGNATURE James Castellano, M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 2-3-62 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James Castellano, M.D.		22d. ADDRESS Relay, 27, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-6-62	
23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		25a. REC'D BY REGISTRAR DATE FEB 7 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

01210

CERTIFICATE OF DEATH

2222

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01589

CERTIFICATE OF DEATH

Reg. Dist. No. 01573

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b X Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8414 Cove Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HAASE Last HAASE		4. DATE OF DEATH Month Feb. Day 25 Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/23/1888
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) caretaker	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ferdinand Haase	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 214-01-1228		17. INFORMANT William E. Haase, son, 8416 Cove Road, 22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 Minutes 5 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1 , 19 62 , to 2-23 , 19 62 , that I last saw the deceased alive on 2-22 , 19 63 , and that death occurred at 4 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William E. Haase M.D.		ADDRESS (Street, city or town, state) 2 Kew-Hip Rd BALT 22	
DATE SIGNED 2-26-62			
PHYSICIAN'S NAME (Type) SAKE C Collins			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/62	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek 3331 Brehms Lane		24a. REC'D BY REGISTRAR DATE FEB 28 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES GILK		2. SEX Male		3. AGE 60	
4. DATE OF DEATH 1914		5. PLACE OF DEATH Home		6. CAUSE OF DEATH Heart Disease	
7. PLACE OF BIRTH Maryland		8. DATE OF BIRTH 1854		9. OCCUPATION Farmer	
10. MARITAL STATUS Married		11. EDUCATION High School		12. RELIGION Roman Catholic	
13. PREVIOUS ILLNESS None		14. MEDICAL HISTORY None		15. SIGNATURE OF PHYSICIAN J. H. Smith	
16. SIGNATURE OF WITNESS J. H. Smith		17. SIGNATURE OF DECEASED J. H. Smith		18. SIGNATURE OF FUNERAL HOME J. H. Smith	
19. SIGNATURE OF REGISTRAR J. H. Smith		20. SIGNATURE OF CLERK J. H. Smith		21. SIGNATURE OF DEPUTY CLERK J. H. Smith	
22. SIGNATURE OF ASSISTANT CLERK J. H. Smith		23. SIGNATURE OF CHIEF CLERK J. H. Smith		24. SIGNATURE OF DEPUTY CHIEF CLERK J. H. Smith	
25. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK J. H. Smith		26. SIGNATURE OF CHIEF DEPUTY CLERK J. H. Smith		27. SIGNATURE OF DEPUTY CHIEF DEPUTY CLERK J. H. Smith	
28. SIGNATURE OF ASSISTANT DEPUTY CHIEF DEPUTY CLERK J. H. Smith		29. SIGNATURE OF CHIEF DEPUTY CHIEF DEPUTY CLERK J. H. Smith		30. SIGNATURE OF DEPUTY CHIEF DEPUTY CHIEF DEPUTY CLERK J. H. Smith	

1. NAME OF DECEASED
JAMES GILK

2. SEX
Male

3. AGE
60

4. DATE OF DEATH
1914

5. PLACE OF DEATH
Home

6. CAUSE OF DEATH
Heart Disease

7. PLACE OF BIRTH
Maryland

8. DATE OF BIRTH
1854

9. OCCUPATION
Farmer

10. MARITAL STATUS
Married

11. EDUCATION
High School

12. RELIGION
Roman Catholic

13. PREVIOUS ILLNESS
None

14. MEDICAL HISTORY
None

15. SIGNATURE OF PHYSICIAN
J. H. Smith

16. SIGNATURE OF WITNESS
J. H. Smith

17. SIGNATURE OF DECEASED
J. H. Smith

18. SIGNATURE OF FUNERAL HOME
J. H. Smith

19. SIGNATURE OF REGISTRAR
J. H. Smith

20. SIGNATURE OF CLERK
J. H. Smith

21. SIGNATURE OF DEPUTY CLERK
J. H. Smith

22. SIGNATURE OF ASSISTANT CLERK
J. H. Smith

23. SIGNATURE OF CHIEF CLERK
J. H. Smith

24. SIGNATURE OF DEPUTY CHIEF CLERK
J. H. Smith

25. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK
J. H. Smith

26. SIGNATURE OF CHIEF DEPUTY CLERK
J. H. Smith

27. SIGNATURE OF DEPUTY CHIEF DEPUTY CLERK
J. H. Smith

28. SIGNATURE OF ASSISTANT DEPUTY CHIEF DEPUTY CLERK
J. H. Smith

29. SIGNATURE OF CHIEF DEPUTY CHIEF DEPUTY CLERK
J. H. Smith

30. SIGNATURE OF DEPUTY CHIEF DEPUTY CHIEF DEPUTY CLERK
J. H. Smith

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01590 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. 1 - Box 169, Owings Mills, Md.				d. STREET ADDRESS Rt. 1 - Box 169			
3. NAME OF DECEASED (Type or print) MARIANNE D. HALL				4. DATE OF DEATH Month February Day 6 Year 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 11, 1961	
9. AGE (In years last birthday) 3 yrs. 26 Months 3 Days 26		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME William Hall				14. MOTHER'S MAIDEN NAME Marianne Luecke			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mr. William Hall				Address Owings Mills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 525 X IMMEDIATE CAUSE (e) Interstitial Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Howard G. Shaub				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED 2/6/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9, 1962		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or country) (State) Norfolk, Va.	
23. FUNERAL DIRECTOR J. F. Eline & Sons				ADDRESS Reisterstown, Md.			
24a. REC'D BY REGISTRAR FEB 9 '62				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01575

1. PLACE OF DEATH e. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 344 Melvin Avenue		d. STREET ADDRESS 344 Melvin Avenue	
3. NAME OF DECEASED (Type or print) First Inez Middle Lela Last Hamilton		4. DATE OF DEATH Month February Day 17 Year 19 62	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1911
9. AGE (In years last birthday) 50		IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private family	
11. BIRTHPLACE (State or foreign country) Lottsburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wayland Nelson		14. MOTHER'S MAIDEN NAME Lula Dorman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-22-7797	
17. INFORMANT Elmer Hamilton - 344 Melvin Avenue		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Hypertensive Cardiovascular Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-17-62 1010 Leach Ave ACTUAL SIGNATURE GEO. S. M. KIEFFER M.D. EXAMINER'S NAME (Type) GEO. S. M. KIEFFER MD 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2-21-62 22c. NAME OF CEMETERY OR CREMATORY Evergreen 22d. LOCATION (City, town, or country) (State) Lottsburg, Virginia 23. FUNERAL DIRECTOR ADDRESS Charles R. Law - 802 Madison Ave., Balto., Mi. 24e. REC'D BY REGISTRAR DATE FEB 21 '62 24f. REGISTRAR'S SIGNATURE Arthur S. House			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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M

Baltimore
 Catonsville
 341 Belvidere Avenue
 Baltimore
 Catonsville
 341 Belvidere Avenue

February 17, 1962
 Hamilton
 30
 1962

Private family
 Baltimore, Virginia
 341 Belvidere Avenue
 341 Belvidere Avenue - 341 Belvidere Avenue

Handwritten:
 341 Belvidere Avenue
 Baltimore, Virginia

GED. 2 M. K. 5 F. 2 R. M. D.
 1010

Baltimore
 2-21-62
 Baltimore

341 Belvidere Avenue - 341 Belvidere Avenue

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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FOR STATE
HEALTH DEPT.

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01592 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										01576	
1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 617 Overbrook Road						d. STREET ADDRESS 617 Overbrook Road					
3. NAME OF DECEASED (Type or print) First NINA Middle Clatborne Last HAMM						4. DATE OF DEATH Month February Day 5 Year 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-14-1914		9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Augusta, Georgia		
12. CITIZEN OF WHAT COUNTRY? U. S. A.											
13. FATHER'S NAME John Claiborne						14. MOTHER'S MAIDEN NAME Mary (?)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War II						16. SOCIAL SECURITY NO.					
17. INFORMANT Mr. John E. Hamm, Jr.						Address -617 Overbrook Road- #12					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate poisoning											
970.2 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) By an overdose of barbiturate					
20c. TIME OF INJURY Hour a.m. 6:00 5:55 Month, Day, Year Feb. 5 19 62						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home						20f. (City or town) (County) (State) 617 Overbrook Road Balto. Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Howard G. Shaub						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						DATE SIGNED 2/6/62					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 2-8-62					
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.						22d. LOCATION (City, town, or country) (State) Baltimore, Maryland					
23. FUNERAL DIRECTOR Wm J. Jenkins & Son						24a. REC'D BY REGISTRAR FEB 7 '62					
						24b. REGISTRAR'S SIGNATURE Arthur S. Thoma					

01570

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SHADY NOOK HOME</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>321 HARLEM LANE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE A. HAMMEL</u>		4. DATE OF DEATH Month Day Year <u>February 3 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 19, 1908</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANCIS R. ROSE</u>		14. MOTHER'S MAIDEN NAME <u>ANNA A.V. STURGIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Eugene Hammel - 321 Harlem Lane</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Intracerebral Hemorrhages</u> 4 43 X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis & Hypertensive Cardio-Vasc.</u> (a), stating the underlying cause last. } DUE TO <u>disease -</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Oct 1960</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>Jan 25, 1962</u> to <u>Feb 3, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb 3, 1962</u> , and that death occurred at <u>H.H.A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Harry W. Knipp, M.D.</u>		22b. DATE SIGNED <u>2-5-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>HARRY W. KNIPP, M.D.</u>		22d. ADDRESS <u>4116 EDMUNDSON AVE #29</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2-6-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Forley-Cavanagh</u>		25a. REC'D BY REGISTRAR <u>FEB 8 '62</u>	
ADDRESS <u>F. H. Catonsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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(M)

February 3, 1922

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OFFICE OF THE ATTORNEY GENERAL

U.S.

Department of Justice

Washington, D.C.

Division of Criminal Investigation

Field Office

San Francisco, California

U.S. DEPT. OF JUSTICE

Division of Criminal Investigation

San Francisco, California

U.S. DEPT. OF JUSTICE

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01595

01579

1. PLACE OF DEATH e. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Ma. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4603 Rehbaum Ave.				d. STREET ADDRESS 4603 Rehbaum Ave			
3. NAME OF DECEASED (Type or print) Frederick Hamson				4. DATE OF DEATH FEB 24 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 11, 1875	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John H. Hamson				14. MOTHER'S MAIDEN NAME Louise			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218 09 1872		17. INFORMANT Mrs. Susie Hamson, 4603 Rehbaum Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac failure Conditions, if any, which gave rise to immediate cause (b) Coronary Vascular Heart disease (c) Arteriosclerosis generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE GEO. S. M. KIEFFER MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) GEO. S. M. KIEFFER MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
		Address (Street, city, town, or county) 1010 Leiden					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/62		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or country) (State) Baltimore 29, Md.	
23. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave				24a. REC'D BY REGISTRAR FEB 28 '62		24b. REGISTRAR'S SIGNATURE Christina S. Hamson	

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01529

(M)

4001 Highway Ave
10/10/52

4001 Highway Ave
10/10/52



Robert Carter
10/10/52

John B. Benson

10/10/52

GEORGE M. KETTER NO

2/26/52

10/10/52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01596

01580

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison c. LENGTH OF STAY IN 1b 6 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Foxleigh Nursing Home		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS 102 Chestnut Hill Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lena First Middle Last Harden		4. DATE OF DEATH Month Day Year Feb. 26, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1893
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days 69	11. IF UNDER 24 HRS. Hours Min. 69
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Washington D.C.	
13. FATHER'S NAME George Harry Williams		14. MOTHER'S MAIDEN NAME Lena Marie Hansmann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Marie Hendricks Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - rectum DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma - Cervix (a), stating the underlying cause last. (c) Metastasis - Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 7 years 1 year 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from... February 19, 1962 to Feb. 26, 1962 , that (I) (we) last saw the deceased alive on... Feb. 22, 1962 , and that death occurred at... 4:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Clarence E. McWilliams M.D.		22b. DATE SIGNED February 26, 1962	
22c. PHYSICIAN'S NAME (Type) Clarence E. McWilliams		22d. ADDRESS Reisterstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 2-27-1962	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Henry James Eckhardt ADDRESS Owings Mills, Md.		25a. REC'D BY REGISTRAR FEB 27 '62	
25b. REGISTRAR'S SIGNATURE Clarence S. Thomas			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01597

01581

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD, Rural</u>		c. LENGTH OF STAY IN 1b <u>41 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD, Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Falls Road</u>				d. STREET ADDRESS <u>Falls Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>EVELYN</u> Last <u>HARMON</u>			4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>1962</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1903</u>		9. AGE (In years lost by day) <u>58</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Winfield Stine</u>			14. MOTHER'S MAIDEN NAME <u>ELSIE IRENE Merryman</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>William Wesley HARMON. HAMPSTEAD, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1</u> 19 <u>42</u> to <u>Feb 6</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Feb 6</u> 19 <u>62</u> and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-6-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				22d. ADDRESS <u>HAMPSTEAD Maryland</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-8-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salem E & B</u>		23d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hipton-Elmer-Hampstead Md</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01599
CERTIFICATE OF DEATH
01582

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. LENGTH OF STAY IN 1b 14 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 Dennison St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES WILLIAM HENDERSON		4. DATE OF DEATH Month Day Year 2-20-62 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-1887
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner-operator		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Henderson		14. MOTHER'S MAIDEN NAME Sarah Wosley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 343-14-1558	
17. INFORMANT A. David Howard,		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF STOMACH DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 mos. 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (was was hospital) attended the deceased from 1958 to FEB 20 19 62 that (I) (was was) last saw the deceased alive on FEB 20 19 62 and that death occurred at 6 P. M. from the causes and on the date stated above.			
22a. SIGNATURE William A. Pillsbury		22b. DATE SIGNED 2-21-62	
22c. PHYSICIAN'S NAME (Type) William A. Pillsbury, M.D.		22d. ADDRESS 2060 York Rd., Timonium, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-26-62	23c. NAME OF CEMETERY OR CREMATORY East Lawn Memorial	
23d. LOCATION (City, town, or county) (State) Bloomington, Illinois.			
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Inc., Towson 4, Md.		25a. REC'D BY REGISTRAR DATE FEB 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01600

01583

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House in the Pines, 16 Fusting Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1217 Linden Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Herbert Last Geise		4. DATE OF DEATH Month February Day 23 Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1884
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Elect. Cont.		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Herbert		14. MOTHER'S MAIDEN NAME Mary Geise	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-32-5358	
17. INFORMANT R. Harry Herbert, 12 N. Carey St. #23		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertensive Cardiovascular Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5 yrs. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 17, 1962 to Feb 23, 1962 that (I) (was) last saw the deceased alive on Feb 22, 1962 and that death occurred at 1 P.M. from the causes and on the date stated above.			
22a. SIGNATURE A. Bradley Daugharthy M.D.		22b. DATE SIGNED Feb 26 '62	
22c. PHYSICIAN'S NAME (Type) A. Bradley Daugharthy, M. D.		22d. ADDRESS 1264 Francis Avenue, Halethorpe 27, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/26/62	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24 FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Avenue #29		25a. REC'D BY REGISTRAR Feb 26 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01601

01584

1. PLACE OF DEATH a. COUNTY Baltimore County 1925 Crafton Ave. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 1925 E Crafton Ave. b. COUNTY Balto. Co. 22	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graceland Park		c. LENGTH OF STAY IN 1b X Graceland Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1925 Crafton Ave. 22	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles J. Hiltner First Middle Last		4. DATE OF DEATH Feb. 27 / 62 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1898
9. AGE (In years lost day) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Corp.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Andrew Hiltner		14. MOTHER'S MAIDEN NAME Mamie Helman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --- (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. 213-07-4278	
17. INFORMANT Mrs Anna. H. Hiltner		Address 1925 Crafton Ave. 22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) CA of Rk. Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1960 to Feb 27 1962 that (I) (we) last saw the deceased alive on Feb 12 1962 and that death occurred at 2:30 PM from the causes and on the date stated above.			
22a. SIGNATURE M B Davis		22b. DATE SIGNED 3/1/62	
22c. PHYSICIAN'S NAME (Type) M B DAVIS M.D.		22d. ADDRESS 6800 MORNINGTON AVE - DUNDAS - 22	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar. 3/62	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.	23d. LOCATION (City, town, or county) (State) Balto. Md.
24. FUNERAL DIRECTOR'S SIGNATURE Philip Newby Sons		ADDRESS 2024 Orleans St. 31	
25a. REC'D BY REGISTRAR MAR 2 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01602 CERTIFICATE OF DEATH 01585

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1210 Stella Drive</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1210 Stella Drive</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bertha</u> <u>Lucilla</u> <u>Hobson</u>		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1887</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Barnsley</u>		14. MOTHER'S MAIDEN NAME <u>Julia Starkey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mrs. B.V. Commarata-1210 Stella Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE CARDIO VASCULAR Disease - 1956</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>ARTERIO SCLEROSIS</u> (c) <u>1950</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1958</u> to <u>Feb. 1962</u> that (I) (we) last saw the deceased alive on <u>2/17/1962</u> and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman R. Kleiman</u> M.D.		22b. DATE SIGNED <u>Feb 19 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>NORMAN R. KLEIMAN</u>		22d. ADDRESS <u>3803 EDMONDSON NE-BALTS-24th</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-21-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Woodlawn, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Suckner & Son</u>		25a. REC'D BY REGISTRAR <u>FEB 19 '62</u>	
ADDRESS <u>Balts 12th</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

08210

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01603
CERTIFICATE OF DEATH
01586

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 4yr8mth16dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Baltimore City Hospitals e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard First Hochmal Middle Last		4. DATE OF DEATH Month February Day 8 Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Bohemia		12. CITIZEN OF WHAT COUNTRY? Bohemia	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. bibe	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 22 1962 to Feb. 8 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 8 1962 , and that death occurred at 7:15 p.m. , from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler M.D.		22b. DATE SIGNED 2-9-62	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF Feb 12 62	
23c. NAME OF CEMETERY OR CREMATORY New Calhoun		23d. LOCATION (City, town or county) (State) old Frederick Road	
24. FUNERAL DIRECTOR'S SIGNATURE House Funeral Home		25a. REC'D BY REGISTRAR 12 16 5 Daily Rt	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE FEB 14 '62	

01598

01598



From June 1st to 15th 1911
and July 1st to 15th 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01604

CERTIFICATE OF DEATH

01587

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore # 24. 3 V01-4		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore # 24.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bent Nursing Home.			d. STREET ADDRESS 410 S. Highland Ave.		
3. NAME OF DECEASED (Type or print) AGATHA AGNES HOEHN.			4. DATE OF DEATH Month February Day 9 Year 19 62.		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1879.	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Work.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Philip Dietz.			
14. MOTHER'S MAIDEN NAME Anna Stock.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			
16. SOCIAL SECURITY NO. None		17. INFORMANT John J. Hoehn			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) CEREBRAL THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4-20-62 DUE TO (b) ARTERIOSCLEROTIC C.V. DISEASE DUE TO (c) PHEUMATOID ARTHRITIS		INTERVAL BETWEEN ONSET AND DEATH 30 min. YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) PHEUMATOID ARTHRITIS					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN. 5 , 19 62 to FEB. 9 , 19 62 . That (I) (we) last saw the deceased alive on FEB. 8 , 19 62 , and that death occurred at 5:30 AM , from the causes and on the date stated above.					
22a. SIGNATURE Martin E. Strobel		22b. DATE SIGNED 2/9/62		22c. PHYSICIAN'S NAME (Type) MARTIN E. STROBEL	
22d. ADDRESS 48 MAIN ST., REISTERSTOWN, MD.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-12-62.		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	
23d. LOCATION (City, town or county) 7401 German Hill Rd., Md.		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Charles J. Zeller		24a. ADDRESS 901 S. Conkling St. Balto., Md.		25a. REC'D BY REGISTRAR DATE FEB 13 '62	
25b. REGISTRAR'S SIGNATURE Charles J. Zeller		25c. DATE 2/13/62			

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Source: *Author's calculations*.

54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063 1064 1065 1066 1067 1068 1069 1070 107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01605
CERTIFICATE OF DEATH

01588

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4220 Darnell Road		d. STREET ADDRESS 4220 Darnell Road	
3. NAME OF DECEASED (Type or print) Mrs. Elizabeth C. Hoffman		4. DATE OF DEATH Month February Day 6 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 17, 1868
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months 6 Days 6	
IF UNDER 24 HRS. Hours 6 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (County & State, or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George R. Yocum		14. MOTHER'S MAIDEN NAME Wilhelmina	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Frank Dunks		Address 4220 Darnell Road Perry Hall, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr Myocarditis 4220 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH 4 yrs 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 12, 1956 to Feb. 6, 1962 , that (I) (we) last saw the deceased alive on Feb. 6, 1962 , and that death occurred at 4:05 A.M. , from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE Samuel B. Wolfe		22c. PHYSICIAN'S NAME (Type) SAMUEL B. WOLFE	
22d. ADDRESS 5508 Belair Road Baltimore		22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 10, 1962	
23c. NAME OF CEMETERY OR CREMATORY Pottstown (West End)		23d. LOCATION (City, town or county) (State) Pottstown, Pennsylvania	
24 FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home		24b. ADDRESS 3631 Falls Road	
24c. DATE FEB 8 '62		24d. REGISTRAR'S SIGNATURE Arthur S. Krause	
24e. REGISTRAR'S SIGNATURE Horse F. Burgee		24f. ADDRESS Baltimore, Maryland	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the funeral director. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01606				CERTIFICATE OF DEATH				01589			
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 76 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clarksville d. STREET ADDRESS -- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EDWARD			First ----			Middle HOLLAND			Last ----		
4. DATE OF DEATH February		Month 4		Day 19		Year 62					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1892		9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Odd jobs				10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (County & State, or foreign country) Highland, Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Frances Holland					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I		17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) ADENOCARCINOMA OF STOMACH WITH METASTASIS TO PANCREAS, LIVER AND REGIONAL LYMPH NODES, OMENTUM AND MESENTERIUM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause test. PNEUMONIA, RIGHT LUNG PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/20/1961 to 2/4/1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 4, 1962 and that death occurred at 12:10P M, from the causes and on the date stated above.											
22a. SIGNATURE Sebastian Russo M.D.						M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/5/62	
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.						22d. ADDRESS VAH, BALTIMORE 18 MD., FT. HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/9/62		23c. NAME OF CEMETERY OR CREMATORY Hopkins Cemetery				23d. LOCATION (City, town or county) (State) Highland, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Robert Snowden						ADDRESS Rockville, Maryland		25a. REC'D BY REGISTRAR FEB 13 '62		25b. REGISTRAR'S SIGNATURE Robert S. Snowden	

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UNIVERSITY OF CALIFORNIA LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01607 CERTIFICATE OF DEATH 01590

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO</u> c. LENGTH OF STAY IN 1b <u>2 mo. 10d. 18hr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSP</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>NORTH BEACH</u> d. STREET ADDRESS <u>ROSE HAVEN</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>HOLMES</u> Last <u>HOLMES</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>24</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/90</u>
9. AGE (In years last birthday) <u>71</u>		10. IF UNDER 1 YEAR <u>71</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>SWEDEN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA?</u>	
13. FATHER'S NAME <u>MATTAIS MATTSON</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>S.G.S.H. RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>BRONCHOPNEUMONIA</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-13</u> 19 <u>61</u> , to <u>Feb 24</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Feb 24</u> , 19 <u>62</u> , and that death occurred at <u>7:35</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Jose R. Arizaga</u>		22b. DATE SIGNED <u>2-24-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSP</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 26, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Harmony Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Mt Airy Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Feb 28 '62</u>	
ADDRESS <u>Owings, Calvert Co, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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Holmes

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1915

John K. Carpenter

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Butterfly

Butterfly

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 9/60

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01608 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
01591									
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE 6 c. LENGTH OF STAY IN lb 20 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5122 Kenwood Avenue					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6 d. STREET ADDRESS 5122 Kenwood Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WINIFRED KEYES HOPPER					4. DATE OF DEATH Month 2 Day 5 Year 19 62				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-7-1912		9. AGE (In years last birthday) 49 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Bakertown W. Va.			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Charles Hopper					14. MOTHER'S MAIDEN NAME Nettie Glassford				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-01-0413		17. INFORMANT Mrs Mildred Hopper Address 5122 Kenwood Ave (6)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. 19 Month, Day, Year p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Peter W Rieckert					CHIEF MEDICAL EXAMINER <input type="checkbox"/> Associate <input checked="" type="checkbox"/> M.D. PETER W. RIECKERT, M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Shepherdston W. Va.				
EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D.					DATE SIGNED 2-5-62				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-8-1962		22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		22d. LOCATION (City, town, or country) (State) Shepherdston W. Va.			
23. FUNERAL DIRECTOR Lassahn Funeral Home		24a. REC'D BY REGISTRAR 240/1 Belair Road		24b. REGISTRAR'S SIGNATURE DATE FEB 8 '62		24c. REGISTRAR'S SIGNATURE Arthur S. Hume			

10610

10610

(M)

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01592

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Penn</u> b. COUNTY <u>Luzerne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilkes Barre</u> 75 X-3			
c. LENGTH OF STAY IN 1b <u>6 wks</u>				d. STREET ADDRESS <u>154 Hawn St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1217 Brandford Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George W Haskins</u> First Middle Last				4. DATE OF DEATH <u>July 11</u> 19 <u>62</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1884</u> 76 Yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Painter Rail Roads</u>				11. BIRTHPLACE (State or foreign country) <u>Penn</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Zebeaux Haskins</u>			
14. MOTHER'S MAIDEN NAME <u>Ellie Fell</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>1217</u>				17. INFORMANT <u>Korena Melhuish Brandford Rd</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart disease</u> 420+1 } DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Cardiovascular disease</u> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>GEO. S. M. RIEFFER MD</u> EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2/15/62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Family Plot</u>				22d. LOCATION (City, town, or country) (State) <u>Wilkes Barre, Pa.</u>			
23. FUNERAL DIRECTOR <u>David L. Davies, Wilkes Barre Pa</u> ADDRESS <u>Edmund Catonsville Md</u>				24a. REC'D BY REGISTRAR <u>1010 L</u> DATE <u>FEB 14 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

2

01505



[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

GEORGE A. KILFER MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> c. LENGTH OF STAY IN 1b <u>3 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>York Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> d. STREET ADDRESS <u>York Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gladys Pauline Howard</u> First Middle Last		4. DATE OF DEATH <u>February 27 1962</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1928</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Parkton, Md.</u>
13. FATHER'S NAME <u>John Wesley Miller</u>		14. MOTHER'S MAIDEN NAME <u>Luella Carr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>918</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 493 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) DUE TO DUE TO DUE TO		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asthma - 4 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>27 Feb 62</u> to <u>27 Feb 62</u> , that (I) (we) last saw the deceased alive on <u>27 Feb 62</u> , and that death occurred at <u>9:18</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Walter T. Kees</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>		22d. ADDRESS <u>Cockeysville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>March 2, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Vessop Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Cockeysville, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Kortenstem, New Freedom, Pa.</u>		25. REC'D BY REGISTRAR <u>1 MAR 1 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

(M)

Ballinger
Cook County
York Rd

Ballinger
Cook County
York Rd

Clayton Eugene Howard
July 6, 1928 33

Clayton Eugene Howard
July 6, 1928 33

Howard
John Wesley Miller
Lucille Carr

Howard
John Wesley Miller
Lucille Carr

Primm

Primm

Calhoun - upper

July 17, 1928

Walter T. Keen
Walter T. Keen

Walter T. Keen
Walter T. Keen

Walter T. Keen
Walter T. Keen
Walter T. Keen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01611

01594

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>7804 Oak Ave.</i>			d. STREET ADDRESS <i>7804 Oak Ave.</i>		
3. NAME OF DECEASED (Type or print) First <i>Frederick Charles</i> Middle <i>Huber</i> Last <i>Huber</i>			4. DATE OF DEATH Month <i>2</i> Day <i>23</i> Year <i>1962</i>		
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Grocer</i>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>85</i> yrs.	
13. FATHER'S NAME <i>Peter Huber</i>		11. BIRTHPLACE (Country & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>215099229</i>		17. INFORMANT <i>Catherine B. Huber</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Influenza</i> 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>			
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from <i>1940</i> to <i>Feb. 23, 1962</i> that (I) (we) last saw the deceased alive on <i>Feb. 23, 1962</i> and that death occurred <i>2:15 P.M.</i> from the causes and on the date stated above.		22a. SIGNATURE <i>A. M. Bacon</i> M.D.			
22c. PHYSICIAN'S NAME (Type) <i>A. M. BACON</i>		22d. ADDRESS <i>2810 Taylor Ave.</i>		22b. DATE SIGNED <i>2/24/62</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>2-26-62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck Inc.</i>		23d. LOCATION (City, town or county) <i>Baltimore,</i>		23e. REC'D BY REGISTRAR <i>27 FEB 1962</i>	
25a. REC'D BY REGISTRAR <i>27 FEB 1962</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Thomas</i>			

01331

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M

Leonard J. ...

A. M. ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. No burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01612

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01595

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>B</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>B. O Railroad</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3001-4	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>1834 Linden Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ulysses</u> Middle <u>(S)</u> Last <u>Hudson</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8 1927</u>
9. AGE (In years last birthday) <u>34</u> -yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Distillery</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>James Hudson</u>	
14. MOTHER'S MAIDEN NAME <u>Carrie Bellomy</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>	
16. SOCIAL SECURITY NO. <u>250-20-7240</u>		17. INFORMANT Address <u>Elizabeth Gee 1834 Linden Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple fractures</u> DUE TO <u>Crushed head</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rail road accident.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>While crossing R.R. tracks hit by fast moving train</u>	
20c. TIME OF INJURY Hour <u>6</u> p. m. Month, Day, Year <u>Feb 19 1962</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rail road</u>		20f. (City or town) (County) (State) <u>Lansdowne Baltimore</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>GEO. S. M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GEO. S. M. Kieffer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u>1010 Leeds Ave</u>		DATE SIGNED <u>Feb 19 1962</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Louis, S.C.</u>		22d. LOCATION (City, town, or county) (State) <u>South Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Holstead</u>		ADDRESS <u>918 David Hill Ave,</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 27 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kimes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01613

CERTIFICATE OF DEATH

Reg. Dist. No. 01596

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOPPA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X JOPPA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt 3, Box 290</u>				d. STREET ADDRESS <u>Rt 3 Box 290</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sr. <u>Edward Joshua Humphreys Sr.</u>				4. DATE OF DEATH Month Day Year <u>2 2 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-6-1888</u>	
9. AGE (In years last birthday) yrs. <u>73</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home Improve.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Millard Humphreys</u>				14. MOTHER'S MAIDEN NAME <u>Christine Burnett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219034713</u>		17. INFORMANT Address <u>A. Louise Humphreys SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA - Probable intracerebral hemorrhage.</u> DUE TO (b) <u>general arteriosclerosis & assoc. ASHD</u> DUE TO (c) <u>& assoc. primary Amyloidosis with hepatic involve.</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> years Unk.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002.2 N/A except arrested inactive TB</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>	
20f. (City or town) <u>N/A</u>				(County) <u>N/A</u>		(State) <u>N/A</u>	
21. I certify that I attended the deceased from <u>July 19</u> , 19 <u>61</u> , to <u>Feb. 2</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Jan. 13</u> , 19 <u>62</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 S. Main - Bel Air, Md.</u> DATE SIGNED <u>2/3/62</u>							
ACTUAL SIGNATURE <u>Warren R. Lesch, M.D.</u>				PHYSICIAN'S NAME (Type) <u>Warren R. Lesch, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/5/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Ruck</u>				ADDRESS <u>5305 HARFORD Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 8 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Ruck</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01614

01597

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 27		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 27	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3605 Annapolis Blvd.,		d. STREET ADDRESS 3605 Annapolis Road	
3. NAME OF DECEASED (Type or print) First Theresa Middle Huppert Last Huppert		4. DATE OF DEATH Month February Day 16 Year 1962	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1878
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Kamerstorf, Austria	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Hansalek		14. MOTHER'S MAIDEN NAME Ingolia (unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Margaret E. Blanck, 3605 Annapolis Road, Zone 27		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic C-V-D 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential Hypertension		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/14/59 , 19 to 2/10/62 , 19, that (I) (we) last saw the deceased alive on 2/13/62 , 19, and that death occurred at 7:20 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Arthur C. Rossberg M.D.		22b. DATE SIGNED 2/10/62	
22c. PHYSICIAN'S NAME (Type) Arthur C. Rossberg, M.D.		22d. ADDRESS 2436 Washington Blvd	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-19-62	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore	
24 FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR FEB 20 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

01503

01503

(M)

(L)

Exhibit C-1

Exhibit C-1

Exhibit C-1

Exhibit C-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01615
CERTIFICATE OF DEATH

01598

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Villa Nova.</u>		c. LENGTH OF STAY IN 1b <u>6 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AULSBURG Home.</u>		d. STREET ADDRESS <u>YORK RD</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>HURLINE</u> Last <u>HURLINE</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>2</u> Year <u>1962</u>	
S. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 9 1882</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Sweet Aire. Mo.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>FRANK.</u>		14. MOTHER'S MAIDEN NAME <u>ODENKIN.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>RECORDS A.H.</u>	
17. INFORMANT <u>6067 CAMPFIELD RD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>11 Broncho. Pneumonia</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2. Antero-Septic Heart Disease</u> DUE TO <u>3. Pathological Gall Bladder</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 yrs</u> <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 24 1960</u> to <u>Feb 2 1962</u> that (I) <u>we</u> last saw the deceased alive on <u>Feb 2 1962</u> and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Earl L. Chambers</u> M.D.		22b. DATE SIGNED <u>2/3/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		22d. ADDRESS <u>4108 Liberty Hts Baltimore Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/6/62</u>	
23c. NAME OF CEMETERY OR CREMATORIUM <u>St. Ignace Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Steuarn Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. 6067 Campfield Rd</u>		25a. REC'D BY REGISTRAR <u>REC'D 8 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>	

01393

CENTRE OF DEATH

01393



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01616

CERTIFICATE OF DEATH

Reg. Dist. No. 01599

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Catonsville md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>199 Winters Lane</u>		d. STREET ADDRESS <u>199 Winters Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Eva Christian Jones</u> First Middle Last		4. DATE OF DEATH <u>Feb 22</u> Month Day Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 20 1908</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>na</u>	
11. BIRTHPLACE (State or foreign country) <u>na</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip Christian</u>		14. MOTHER'S MAIDEN NAME <u>Fate Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>230-18-1579</u>	
17. INFORMANT <u>Lorine Covington</u> Address <u>2813 Brighton St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>(b) Hypertensive Arterio-sclerosis I yr. 9 Mo. 22 Days</u> DUE TO <u>(c)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u> <u>Hypostatic Pneumonia (Pneumonia)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr-16th</u> , 1960, to <u>Feb-22nd</u> , 1962, that I last saw the deceased alive on <u>Feb-22nd</u> , 1962, and that death occurred at <u>9.30A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C.F. Maloney, M.D.</u> M.D. <u>57</u> ADDRESS (Street, city or town, state) <u>87 Winters Lane</u> DATE SIGNED <u>2/22/62</u>			
PHYSICIAN'S NAME (Type) <u>C.F. Maloney, M.D.</u>		<u>Catonsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-25-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Point Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>West Point Na</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. H. Nelson</u> ADDRESS <u>1748 N. Calhoun St</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01617

01600

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN IS 25 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 16 3101-4 d. STREET ADDRESS 1409 Poplar Grove Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH W. JONES First Middle Last 4. DATE OF DEATH February 8 1962 Month Day Year		5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH June 3, 1892 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) 69 yrs. 10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) Trackman (Laborer) 10b. KIND OF BUSINESS OR INDUSTRY Railroad 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Wilson Jones 14. MOTHER'S MAIDEN NAME Jennie Moody	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I 16. SOCIAL SECURITY NO. 705-12-5462 17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANTEROLATERAL MYOCARDIAL INFARCTION 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c) PULMONARY EDEMA INTERVAL BETWEEN ONSET AND DEATH 2 HOURS UNKNOWN 2 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriolar nephrosclerosis. Left ventricular hypertrophy.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from January 14 1962, to February 8, 1962, that (X) (we) last saw the deceased alive on February 8 1962, and that death occurred at 10:20 P.M., from the causes and on the date stated above.			
22a. SIGNATURE Sebastian Russo M.D. 22b. DATE SIGNED 2/8/62 M.D. 22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D. 22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/13/62 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery 23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Adolphus Halstead ADDRESS Adolphus Halstead, 918 Druid Hill Ave., Balto, Md.		25a. REC'D BY REGISTRAR FEB 13 1962 25b. REGISTRAR'S SIGNATURE Charles S. K...	

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[illegible]

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

[illegible]

[Faint handwritten notes at the bottom of the page:]

Dover L-3 to Mt. Liberty Cem.
H.A. County, N.H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

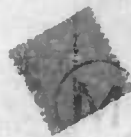
VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1810 West Lombard St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles P. Kaminski (Kamzemer)		4. DATE OF DEATH Feb. 3, 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1890
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tailor		10b. KIND OF BUSINESS OR INDUSTRY Lithuania	
11. BIRTHPLACE (County & State, or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? Lithuania	
13. FATHER'S NAME Joseph Kaminski		14. MOTHER'S MAIDEN NAME Rosalie Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-01-9031	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. DUE TO (b) Arteriosclerosis, generalized. DUE TO (c) Fibroid and pulmonary tuberculosis, arrested	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (X) (this hospital) attended the deceased from Jan. 23, 1961 , to 1961 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.	
22a. SIGNATURE Ricardo Ibanez M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) RICARDO IBANEZ		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/6/62	
23c. NAME OF CEMETERY OR CREMATORY Holy Reddemer Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Avenue #29		25a. REC'D BY REGISTRAR FEB 5 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

01805

01819



CERTIFICATE OF DEATH

Reg. Dist. No. **01603**

01620

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VILLA NOVA.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO MD. 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HUGSBURG Home				d. STREET ADDRESS 2760 E 1710 WASH. ST.			
3. NAME OF DECEASED (Type or print) MARTHA Keen.				4. DATE OF DEATH Month Feb. Day 14. Year 1962			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/74.	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) BALTO MD.		12. CITIZEN OF WHAT COUNTRY? -	
13. FATHER'S NAME F. E. HAMMER				14. MOTHER'S MAIDEN NAME ELIZ. BUTCHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		INFORMANT Records A.H. 6811 Campfield Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 21. Diabetes Mellitus DUE TO (c) 31. Urine Infection							INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs. 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio Sclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/14 , 19 61 , to 2/14 , 19 62 , that I last saw the deceased alive on Feb. 13 , 19 62 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Earl L. Chambers				M.D. 4108 Liberty Hts. Balt. Md.		DATE SIGNED 2-16-62	
PHYSICIAN'S NAME (Type) Earl L. Chambers				4108 Liberty Hts. Balt. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Feb 16. 62		22c. NAME OF CEMETERY OR CREMATORY BALTO. Cem.		22d. LOCATION (City, town, or county) (State) BALTO MD	
23. FUNERAL DIRECTOR'S SIGNATURE J. A. Heemann				ADDRESS 6067 HARE RD.		24a. REC'D BY REGISTRAR DATE FEB 21 '62	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01803

CENTRAL BANK

01803



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01621
01604
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Summit Nursing Home, Smithwood & Summit Aves.				d. STREET ADDRESS 421 S. Vincent Street			
3. NAME OF DECEASED (Type or print) First Henrietta Middle E. Last Keith				4. DATE OF DEATH Month February Day 16 Year 1962			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 9, 1886	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sewing mach. operator				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.			
11. BIRTHPLACE (County & State, or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Julius Eckart				14. MOTHER'S MAIDEN NAME Emma Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. Edna M. Heffter, 2204 Pleasant Dr. #28			
17. INFORMANT Edna M. Heffter, 2204 Pleasant Dr. #28				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis (a), or testing the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 2 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12 30 , 1962 to 2 16 , 1962 , that (I) (we) last saw the deceased alive on 2 16 , 1962 , and that death occurred at 10 15 A.M., from the causes and on the date stated above.							
22a. SIGNATURE Justin Kudirka				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Justin Kudirka, M. D.				22d. ADDRESS 2151 Wilkens Avenue #23			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/19/62		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 29, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Avenue, #29				25a. REC'D BY REGISTRAR FEB 19 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

10010

10010

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Howard H. Hibbard, 6107 Wilkerson Avenue, #22

Edward J. Hibbard

John H. Hibbard, 6107 Wilkerson Avenue, #22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01622

CERTIFICATE OF DEATH

Item 23b File 0307 2/23/62 ink

01605

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN IS 12 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 825 N. Dallas Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE W. KESS		4. DATE OF DEATH Month Day Year FEBRUARY 17 1962	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/29/96
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Chemical Company	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Kess		14. MOTHER'S MAIDEN NAME Annie Boone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 212-01-5140	
17. INFORMANT Clin. Rec. VAH, Balto 18, Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC HEART DISEASE (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 1/1 (this hospital) attended the deceased from Feb. 5 6:15 AM to Feb. 17 , 1962, that 1/1 (we) last saw the deceased alive on Feb. 17 , 1962, and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE M. Lawrence Rubin M.D.		22b. DATE SIGNED 2/17/62	
22c. PHYSICIAN'S NAME (Type) M. LAWRENCE RUBIN, M.D.		22d. ADDRESS VAH, BALTO 18, MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hayes		25a. REC'D BY REGISTRAR FEB 19 '62	
ADDRESS 638 N. Gilmore Street Baltimore, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

11602

01652

M

12 days
12 days

Veterans Administration Hospital

6/23/95
6/23/95

General Hospital, Army Medical Center, D.C.

Private Room

6/23/95
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Michael P. Hayes
Michael P. Hayes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01606

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Md.		c. LENGTH OF STAY IN 1b Towson, 4, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1306 Gateshead Road		d. STREET ADDRESS 1306 Gateshead Rd.	
3. NAME OF DECEASED (Type or print) First ALICE Middle LOUISE Last KING		4. DATE OF DEATH Month Feb. Day 20 Year 19 62	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1876
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) Maryland
10a. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David F. Haynes		14. MOTHER'S MAIDEN NAME Elizabeth Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Wm. H. Keidel		Address Towson, 4, 1306 Gateshead Rd. / Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 420.00 DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 15, 1962 to Feb. 20, 1962 that (I) (we) last saw the deceased alive on Feb. 15, 1962 and that death occurred at 10 PM from the causes and on the date stated above.			
22a. SIGNATURE A.S. Chalfant		22b. DATE SIGNED Feb. 20, 1962	
22c. PHYSICIAN'S NAME (Type) A.S. CHALFANT		22d. ADDRESS 6210 YORK ROAD, Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation Feb. 23, '62		23b. DATE THEREOF Greenmount	
23c. NAME OF CEMETERY OR CREMATORY Baltimore, Maryland		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc.		25a. REC'D BY REGISTRAR FEB 23 '62	
25b. REGISTRAR'S SIGNATURE Carlton J. Thomas			

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(M)

Baltimore Maryland

Baltimore

Towson, Md. Maryland

Towson, Md.

1300 Gateshead Rd.

1300 Gateshead Road

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ALICE LOUISE KING

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Oct. 7, 1925

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U.S.A.

Maryland

Honolulu

Elizabeth Davis

David F. Haynes

Towson, Md.

Mrs. Wm. B. Kibbel, 1300 Gateshead Rd., Md.

None

No

Greenmount Rd. 23, 162

Wm. Cook-Town, Inc. 1030 York Rd.

Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01624 CERTIFICATE OF DEATH 01607

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore, County</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm, Md.</u> d. STREET ADDRESS <u>Long Green Rd.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Long Green</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Long Green</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ross G. Kirk</u>				4. DATE OF DEATH Month Day Year <u>February 22, 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 7, 1887</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Farmer</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Balto. County, Md.</u>			
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>John Kirk</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-12-6664</u>			
17. INFORMANT <u>Mrs. R. G. Kirk</u>				Address <u>Long Green Rd. Glen Arm, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery thrombosis</u> DUE TO (b) <u>Angina pectoris</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arterio Sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio Sclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>2/15, 1962</u> , to <u>2/22, 1962</u> , that (I) (we) last saw the deceased alive on <u>2/22 1962</u> , and that death occurred at <u>6 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Gordon Grau</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Gordon Grau, M.D.</u>				22d. ADDRESS <u>8523 Loch Raven Blvd, Balto. 4, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/28/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Randallstown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Fisher - Sons Inc. North & Ave. Balto. Md.</u>				25a. REC'D BY REGISTRAR <u>Feb 26 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>William S. France</u>							

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CERTIFICATE OF DEATH

Reg. Dist. **01608**

01625

1. PLACE OF DEATH a. COUNTY Balto MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE			
c. LENGTH OF STAY IN 1b 70 yrs				d. STREET ADDRESS 3002 Acton Rd			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3002 Acton Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EUNICE Middle I Last KOETTING				4. DATE OF DEATH Month FEB Day 13 Year 1962			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 13, 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 13 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY GERMANY	
11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME EDWARD SAUTTER		14. MOTHER'S MAIDEN NAME BARBARA FICK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		INFORMANT WM E. KOETTING SR.		Address 3002 Acton Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Occlusion 4-20-1 DUE TO Myocardial Degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Chronic Congestive Heart Failure				INTERVAL BETWEEN ONSET AND DEATH Sudden 2+yr. 10+yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 55 to Feb , 19 62 , that I lost saw the deceased alive on Jan 15 , 19 62 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank T. Kasik Jr.		M.D. 9005 Hafford Rd.		ADDRESS (Street, city or town, state) Balto 14 Md		DATE SIGNED 2/14/62	
PHYSICIAN'S NAME (Type) FRANK T. KASIK JR. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-15-62		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE C. F. EVANS & SON				ADDRESS 8802 Harford Rd		24a. REC'D BY REGISTRAR FEB 16 '62	
				24b. REGISTRAR'S SIGNATURE Arthur S. Plummer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dis. No. **01609**

01626

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoneleigh		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoneleigh	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 607 Stoneleigh Rd.		d. STREET ADDRESS 607 Stoneleigh Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary First E. Middle Krieger Last		4. DATE OF DEATH Feb. 18 Month 18 Day 1962 Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1873
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME George Balster		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --- (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. ---	
INFORMANT Mrs. Schisler		Address 609 Stoneleigh Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Myocardial Heart disease DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 months 15 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 July, 1938 to 18 Feb. 1962 that I last saw the deceased alive on 18 Feb. 1962 , and that death occurred at 9 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles H. Pies M.D.		ADDRESS (Street, city or town, state) 6701 York Rd Baltimore Md	
DATE SIGNED 19 Feb 62			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/20/62	22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE P. A. Heemann		ADDRESS 6067 Harford Rd.	
24a. REC'D BY REGISTRAR DATE FEB 21 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE OF TEXAS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01627

01610

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY in lb 25 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 541 S. 47th Street				d. STREET ADDRESS 541 S. 47th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anthony David Kulakowski				4. DATE OF DEATH Month 2 - Day 19 Year 1962			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-13-1911		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) repair man		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Pittsburg		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Anna Kulakowski 541 S. 47th Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M. B. Davis M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/19/62	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 2-22-62		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn	
23. FUNERAL DIRECTOR Walter Dabrowski 1005 Dundalk Ave.				22d. LOCATION (City, town, or country) Baltimore, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
24a. REC'D BY REGISTRAR DATE FEB 20 '62							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01628

01611

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY in 1b 9yr6mth24dys		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2118 Boundary Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James		First		Middle		Last Lancaster		4. DATE OF DEATH February 6 1962		Month		Day		Year	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1885 (1885)		9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.									
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown		16. SOCIAL SECURITY NO. 232-09-5423-A		17. INFORMANT Records : SPRING GROVE STATE HOSPITAL		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422d DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerosis, generalized and severe PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore		(State) Maryland					
21. I certify that (If this hospital) attended the deceased from July 15, 1952, to Feb. 6, 1962, that (I) (we) last saw the deceased alive on Feb. 6, 1962, and that death occurred at 5:15 P.M. from the causes and on the date stated above.															
22a. SIGNATURE Stella Wachslar M.D.		22b. DATE 2-6-62		22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 2-8-62		23c. NAME OF CEMETERY OR CREMATORY Nethken Hill Cemetery		23d. LOCATION (City, town or county) Blaine, St. Va.		(State) Virginia							
24. FUNERAL DIRECTOR'S SIGNATURE John B. Connelley		ADDRESS Essex 21, Md.		25. REC'D BY REGISTRAR FEB 8 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraw									

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15M
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEAR Woodlawn		c. LENGTH OF STAY IN b 2 yrs		2. USUAL RESIDENCE (If here deceased lived, if Institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dogwood Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville, Maryland		f. STREET ADDRESS 12 LINDEN TERRACE		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Roy Allen Lentz		4. DATE OF DEATH February 13 1962		5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1940		9. AGE (In years last birthday) 21 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wm Lentz		14. MOTHER'S MAIDEN NAME HAZEL EVELYN SHIPE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT FRANCES ELIZABETH PEREJOY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 822X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		Crushing injury to skull with severe cranio-cerebral damage		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Truck fell on man, after drifting back and overturning over side of 5 ft. wall		20c. TIME OF INJURY Hour 5:39 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> Month, Day, Year Feb. 13 1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dogwood Road, Alberta Road	
20f. (City or town) Balto.		20g. (County) Balto.		20h. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R Breitenecker		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED February 14, 1962	
EXAMINER'S NAME (Type) Rudiger Breitenecker, M. D.		Address (Street, city, town, or county) February 14, 1962		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-16-62		22c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEM	
22d. LOCATION (City, town, or country) (State) Finksburg, Md		23. FUNERAL DIRECTOR Donald H. Neall, Pikesville, Md		24a. REC'D BY REGISTRAR Feb 16 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

M

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RECEIVED
JAN 10 1941

1941

Charles W. Smith
Mass. Electric
Ship

James E. Smith

Mass. Electric
Ship

Mass. Electric
Ship
James E. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> c. LENGTH OF STAY IN 1b <u>7</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1540 Ingleside Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Baltimore 7</u> d. STREET ADDRESS <u>1630 Ingleside Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>OLIVE LARUE LOWE</u> First Middle Last		4. DATE OF DEATH <u>Feb. 24</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 18, 1894</u> Yrs. Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind</u>	11. BIRTHPLACE (County & State, or foreign country) <u>U. S.</u>
13. FATHER'S NAME <u>Lilburn Evans</u>		14. MOTHER'S MAIDEN NAME <u>Stanbury</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>67</u>	
17. INFORMANT <u>Arner Lowe</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4-20-00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>60</u> , to <u>2/24</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/23</u> , 19 <u>62</u> , and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Max J Miller M.D.</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MAX J MILLER M.D.</u>		22d. ADDRESS <u>1047 Ingleside Ave (28)</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2/27/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John</u>	23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Smith - Son (28)</u> ADDRESS		25a. REC'D BY REGISTRAR DATE <u>FEB 28 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

01813

01813

(M)

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For signature

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

01631

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01614

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY in 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 109 Midhurst Road				d. STREET ADDRESS 109 Midhurst Road #12		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lula Taylor Loweree				4. DATE OF DEATH Month February Day 25 Year 19 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-15-1910	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Westminster, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Ross E. Taylor				14. MOTHER'S MAIDEN NAME Annie M. Schaefer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. Francis H. Loweree, Sr.				Address -109 Midhurst Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/27/45 , 19....., to 2/23/62 , 19....., that (I) (we) last saw the deceased alive on 2/23/62 , 19....., and that death occurred at 9 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Francis W. Gluck M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/26/62	
22c. PHYSICIAN'S NAME (Type) Francis W. Gluck				22d. ADDRESS 100 W University PKwy			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-28-62		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town or county) (State) Pkesville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Gluck				ADDRESS Baltimore 17, Md		25a. REC'D BY REGISTRAR DATE MAR 1 '62	
				25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

11010

11010

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01632

01615

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Howard</u> c. LENGTH OF STAY IN 1b <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Philadelphia</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> d. STREET ADDRESS <u>1311 North Laurence Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WITOLD</u> First <u>MARKUN</u> Middle Last				4. DATE OF DEATH <u>February</u> <u>20</u> <u>19 62</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26, 1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postal Civil Service Dept.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Matthew Markun</u>			
14. MOTHER'S MAIDEN NAME <u>Julia Tuikor</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Clinical Records, VAH, Baltimore 18, Maryland</u> <u>FORT HOWARD DIVISION</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE POSTEROLATERAL MYOCARDIAL INFARCTION</u> DUE TO (b) <u>LEFT CORONARY ATHEROMATOUS OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HEMOPERICARDIUM DUE TO RUPTURE OF MYOCARDIUM</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>Feb. 18</u> <u>1962</u> to <u>Feb. 20</u> <u>1962</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>Feb. 20</u> <u>1962</u> , and that death occurred at <u>1:35</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Sebastian Russo</u>				22b. DATE <u>2/21/62</u>		22c. PHYSICIAN'S NAME (Type) <u>SEBASTIAN RUSSO, M.D.</u>	
22d. ADDRESS <u>VAH, BALTO 18 MD FT HOWARD DIVISION</u>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>2-23-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beverly National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Beverly, New Jersey</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 26 '62</u>			
25b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Shipped to: W.C. Snover Funeral Home, 478 Cooper St. Beverly, N.J.

7,1330

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01633
01616
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 13 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1220 Linden Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT D. MATON		4. DATE OF DEATH Month February Day 22 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1890
9. AGE (In years) 71 yrs.		10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY Bank	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Maton		14. MOTHER'S MAIDEN NAME Elizabeth Dorsey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 217-14-5545	
17. INFORMANT Clin. Rec. VAH, Balto. Md. - Ft. Howard Div.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 1 Year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from February 9, 1962 to February 22, 1962 , that (X) (we) last saw the deceased alive on February 22, 1962 , and that death occurred at 8:10 PM from the causes and on the date stated above.			
22a. SIGNATURE Irving Freeman M.D.		22b. DATE SIGNED 2/23/62	
22c. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M. D.		22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIV	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Feb 26, 1962	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town or county) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Leo G. Cook		25a. REC'D BY REGISTRAR FEB 27 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. [Signature]			

Baltimore, Md.

01616

01633



Western Administration Hospital

12 days

12 days

12 days

12 days

ROBERT

U. I.

ROBERT

ROBERT

White

June 8, 1950

Bank for Operations

Business Center

for

for

for

for

for

for

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01634

CERTIFICATE OF DEATH

01617

1. PLACE OF DEATH a. COUNTY BALTIMORE CO. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 930 DULANEY VALLEY ROAD		2. USUAL RESIDENCE (Where deceased lived, if institution; Residencia before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON d. STREET ADDRESS 930 DULANEY VALLEY ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HATTIE COMPTON MAXWELL		4. DATE OF DEATH Month Day Year FEBRUARY 26 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 28, 1883
9. AGE (In years last birthday) 78 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
12. CITIZEN OF WHAT COUNTRY? USA		13. BIRTHPLACE (County & State, or foreign country) VIRGINIA	
14. FATHER'S NAME BUSHROD THOMAS MADDOX		15. MOTHER'S MAIDEN NAME LUCY WEAKLEY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NONE		17. SOCIAL SECURITY NO. NO	
18. CAUSE OF DEATH [Enter only one causa par lina for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying causa last. } DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (c) FAMILY RECORDS		INTERVAL BETWEEN ONSET AND DEATH 12 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE RIGHT HIP - OPERATION OCT. 22, 1961		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) SLIPPED WHILE TRYING TO SIT ON BED PAN ON A CHAIR		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. OCT 21 1961 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOSPITAL		20f. (City or town) (County) (State) BALTO. Md.	
21. I certify that (I) (the hospital) attended the deceased from 1/17, 1962 to 2/26, 1962 that (I) (we) last saw the deceased alive on 2/26, 1962 , and that death occurred at 8:35 M, from the causes and on the date stated above.			
22a. SIGNATURE T. C. Siwinski		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) T. C. Siwinski, M.D.		22d. ADDRESS 206 W. Pennsylvania Avenue, Towson 4, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/1/62	
23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY		23d. LOCATION (City, town or county) (State) PARKVILLE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons' Lowson, Md.		25a. REC'D BY REGISTRAR MAR 2 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thane			

(M)

1184

1184

BATHING OF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
CERTIFICATE OF DEATH											
Reg. Dist. No. 01618											
1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARMELITE MONASTERY				d. STREET ADDRESS 1318 DULANEY VALLEY RD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SR. MARY OF THE CHILD JESUS MC COY				4. DATE OF DEATH FEB. 6 1962							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887		9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS SISTER CARMELITE				10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME JOHN LOUIS MCCOY				14. MOTHER'S MAIDEN NAME LILY SCHARF							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT MOTHER CELINE 1318 DULANEY VALLEY RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis accident INTERVAL BETWEEN ONSET AND DEATH years											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from Dec 1955 to 2/6 1962 , that I last saw the deceased alive on 2/6 1962 , and that death occurred at 6:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED											
ACTUAL SIGNATURE MD Dugan M.D.											
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL											
22b. DATE THEREOF FEB. 10, 1962											
22c. NAME OF CEMETERY OR CREMATORY CATHEDRAL CEMETERY BALTIMORE											
22d. LOCATION (City, town, or county) (State)											
23. FUNERAL DIRECTOR'S SIGNATURE H.W. MEARS & SON 805 N. CALVERT ST. ADDRESS											
24a. REC'D BY REGISTRAR FEB 9 '62 DATE											
24b. REGISTRAR'S SIGNATURE William L. Thomas											

CERTIFICATE OF DEATH

1918

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1918		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Farmer		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Name of Physician		Name of Registrar		Name of Coroner	
Dr. J. Smith		J. Doe		J. Doe	
Address of Physician		Address of Registrar		Address of Coroner	
123 Main St.		456 Main St.		789 Main St.	
City		City		City	
Baltimore		Baltimore		Baltimore	
State		State		State	
Maryland		Maryland		Maryland	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01636
CERTIFICATE OF DEATH
01619

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>118 Manor Road</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u> d. STREET ADDRESS <u>118 Manor Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Marie</u> First Middle Last 4. DATE OF DEATH <u>February 13</u> 19 <u>62</u> Month Day Year		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 22, 1886</u> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John J. Walsh</u> 14. MOTHER'S MAIDEN NAME <u>CATHERINE Holden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address <u>Mr. Joseph Mc Naney 118 Manor Rd.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cardiovascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/10/59</u> to <u>2/13</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/13</u> , 19 <u>62</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Victor F. King MD</u> M.D. 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS <u>1102 E. Yopp Rd - Towson</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/17/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Long Green, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc 5305 Harford Road</u> ADDRESS 25a. REC'D BY REGISTRAR <u>FEB 20 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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1133



Leonard J. Ford, 2205 Maryland Ave.
Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12 01637 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01620

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN lb <u>6 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1409 Forest Park Ave</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 23</u> <u>3v01-4</u> d. STREET ADDRESS <u>108 S. Gilmore St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clement Henry Melder Sr.</u>				4. DATE OF DEATH Month Day Year <u>Feb 19 1962</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1894</u>		9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sheriff deputy-retired police</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>police</u>				11. BIRTHPLACE (State or foreign country) <u>Penth Amboy, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clement Henry Melder</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>No.</u>				16. SOCIAL SECURITY NO. <u>220-36-7373</u>				17. INFORMANT Address <u>Mrs Clement H. Melder, 108 S. Gilmore St</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> (b) <u>coronary artery disease</u> (c) <u>arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 yrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
2Dc. TIME OF INJURY Hour a.m. p.m. <u>19</u>			2Dd. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>			2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			2Df. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>J. Raymond Gladue</u> M.D. EXAMINER'S NAME (Type) <u>J. Raymond Gladue</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>701 Brookwood Rd (29)</u> (State)					
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF <u>Entombment 2/23/62</u>			22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Mausoleum Woodlawn Md.</u>			22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR <u>Witzke, 4101 Edmondson Ave.</u>						24a. REC'D BY REGISTRAR <u>DATE FEB 21 '62</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur E. L...</u>		

01830



ST-22-100

ST-22-100
ST-22-100

01638

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01621

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAPE MAY BEECH				c. LENGTH OF STAY IN 1b X CAPE MAY BEECH			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 426 Katherine Avenue				d. STREET ADDRESS 426 Katherine Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FRANCES Middle J. MIDDLETON Last 				4. DATE OF DEATH Month FEB. Day 28, Year 1962			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 27, 1884		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME PHILLIP PROFF.				14. MOTHER'S MAIDEN NAME CATHERINE SCHLIMM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 		17. INFORMANT Address MRS MARIE SCHMUCK 441 S. ROBINSON ST.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4220 IMMEDIATE CAUSE (a) A-S-C-V-DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) 	(County) 	(State) 	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/8/62	
EXAMINER'S NAME (Type) M. B. Davis M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/2/62	22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		22d. LOCATION (City, town, or county) BALTIMORE MD.		(State) 	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC.				24a. REC'D BY REGISTRAR DATE MAR 5 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hanes	
BALTIMORE MARYLAND.							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01639

01622

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 9 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 27 d. STREET ADDRESS 3003 Hammonds Ferry Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEO --- MILLER			4. DATE OF DEATH February 27 1962				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> May 8, 1896			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Armour (Meat Co)		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			
13. FATHER'S NAME George Miller			14. MOTHER'S MAIDEN NAME Mary Ziegler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 215056368		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, STOMACH, WITH METASTASIS, LEFT TESTICLE 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH UNKNOWN </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Pulmonary Edema. Terminal Pneumonia.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 18 1962 , to February 27 1962 , that xx (we) last saw the deceased alive on February 27 1962 , and that death occurred at 1:20 from the causes and on the date stated above.							
22a. SIGNATURE 			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/27/62		
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.			22d. ADDRESS VAH, BALTO 18 MD. FT HOWARD DIVISION				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-62		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			
23d. LOCATION (City, town or county) Baltimore, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE 			25a. REC'D BY REGISTRAR MAR 1 '62				
25b. REGISTRAR'S SIGNATURE 							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part I may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01640

Item 8 Film G308 3/12/62 iwk

01623

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Towson c. LENGTH OF STAY IN 1b Rural -- Towson d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Villa Maria, Notch Cliff		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -- Towson d. STREET ADDRESS Glenarm, Maryland e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sister Mary Perpetua (Miller)		4. DATE OF DEATH Month Day Year February 25 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1874 March 27, 1874
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Religious.	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Frederick Miller		14. MOTHER'S MAIDEN NAME Mary Eck	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister M. Henrica		Address Villa Maria, Glenarm, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized Arterio-sclerosis (a), stating the underlying cause test. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 weeks 12 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from August 1959 to February 1962 , that (I) (we) last saw the deceased alive on Feb. 21 1962 , and that death occurred at 3:45 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Charles F. O'Donnell M.D.		22b. DATE SIGNED February 28 1962	
22c. PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell		22d. ADDRESS 7501 York Road Towson 4, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-27-62.	
23c. NAME OF CEMETERY OR CREMATORY Villa Maria Cem.		23d. LOCATION (City, town or county) (State) Notch Cliff nr Towson.Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Seiler ADDRESS 901 S. Conkling St. Balto., Md.		25a. REC'D BY REGISTRAR FEB 28 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thane			

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

0325

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01641

01624

| | | | | | | | |
|---|---|--|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE Md. b. COUNTY Md. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
8533 Chestnut Oak Road | | | | d. STREET ADDRESS
8533 Chestnut Oak Road | | | |
| 3. NAME OF DECEASED (Type or print)
Lula B. Monks | | | | 4. DATE OF DEATH
Feb. 10, 19 62 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 9, 1885 | 9. AGE (In years last birthday)
76 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Noah Reese | | | 14. MOTHER'S MAIDEN NAME
Magadeline Schmidt | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No No | | 16. SOCIAL SECURITY NO.
None | 17. INFORMANT
Mr. Albert Monks Towson, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary artery occlusion
DUE TO (b) Coronary arterio sclerosis
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/15 19 62 to 2/10 19 62 , that (I) (we) last saw the deceased alive on 2/10 19 62 , and that death occurred at 9:00 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Gordon Grau | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2/12/62 | | |
| 22c. PHYSICIAN'S NAME (Type)
Gordon Grau, M.D. | | | 22d. ADDRESS
8523 Loch Raven Blvd. Balto. 4, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Feb. 13, 1962 | 23c. NAME OF CEMETERY OR CREMATORY
Wesley Cemetery | 23d. LOCATION (City, town or county) (State)
Carroll Co. Md. | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
J. F. Eline & Sons | | | ADDRESS
Reisterstown, Md. | | 25a. REC'D BY REGISTRAR
DATE FEB 14 '62 | 25b. REGISTRAR'S SIGNATURE
Charles L. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01642

CERTIFICATE OF DEATH

Reg. Dist. No.

01625

| | | | |
|--|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | c. LENGTH OF STAY IN lb
6 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Res., 503 Trappe Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WM Harmon Montgomery Sr. | | 4. DATE OF DEATH 2 Month 22 Day 1962 Year | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 26, 1905 |
| 9. AGE (In years last birthday) 56 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Crew Clerk | | 12. KIND OF BUSINESS OR INDUSTRY
Patapsco RR | |
| 13. BIRTHPLACE (State or foreign country)
Maryland | | 14. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. FATHER'S NAME
John A. Montgomery | | 16. MOTHER'S MAIDEN NAME
Alma Sumwalt | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 18. SOCIAL SECURITY NO. 705-10-965 | |
| 19. INFORMANT Norma Montgomery | | Address 503 Trappe Rd., 22, Md.. | |
| 18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of jaw
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
16 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1-10 , 19 61 , to 2-22 , 19 62 , that I last saw the deceased alive on 2-21 , 19 61 , and that death occurred at 5:15 M, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 2115 N. Rip DATE SIGNED 2-22-62 | |
| ACTUAL SIGNATURE Jack P. Collins | | M.D. Beetle M. M.D. | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2-24-1962 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Meadowridge Memorial | | 22d. LOCATION (City, town, or county) (State)
Washington Blvd. Md.. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
JOHN J. DUDA | | ADDRESS 7922 Wise Ave. 22, Md. | |
| 24a. REC'D BY REGISTRAR
DATE FEB 26 '62 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hous | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01643

01626

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|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Summit Nursing Home, Summit & Smithwood Aves. 204 Charles Road | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md.
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
N. Linthicum
d. STREET ADDRESS
02X-2
a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
William H. Morrison | | | 4. DATE OF DEATH
Month Day Year
Feb. 16, 1962 | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
June 10, 1885 | | 9. AGE (In years last birthday)
76 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired, Painter | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
US | | 13. FATHER'S NAME
Elijah H. Morrison | |
| 14. MOTHER'S MAIDEN NAME
Alice French | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
no | | 16. SOCIAL SECURITY NO.
214-16-6527 | |
| 17. INFORMANT
Jennie Morrison, 204 Charles Rd. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral Thrombosis
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Atherosclerosis heart disease
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
5 Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour e.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
Baltimore | | 20g. (County)
Baltimore | | 20h. (State)
Md. | |
| 21. I certify that (I) (this hospital) attended the deceased from June 1961 to Feb. 1962 that (I) (we) last saw the deceased alive on Feb. 10, 1962 and that death occurred at P.M. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Bahram Sina | | | 22b. DATE SIGNED
Feb 17, 1962 | | |
| 22c. PHYSICIAN'S NAME (Type)
Bahram Sina, M. D. | | | 22d. ADDRESS
529 S. Camp Meade Road | | |
| 23a. BURIAL, CREMATION, REMOVAL, etc.
Burial | | 23b. DATE THEREOF
2/19/62 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn | |
| 23d. LOCATION (City, town or county)
Baltimore County, Md. | | 23e. REC'D BY REGISTRAR
DATE FEB 19 '62 | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
Howard H. Hubbard, 4107 Wilkens Avenue #29 | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Harris | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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CERTIFICATE OF DEATH

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|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
PHOENIX | | c. LENGTH OF STAY IN lb
PHOENIX | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
AT HOME | | d. STREET ADDRESS
SWEET AIR ROAD | |
| 3. NAME OF DECEASED
(Type or print)
LYNDE ELISABETH MOSNER | | 4. DATE OF DEATH
Month FEBRUARY Day 15 Year 1962 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 20, 1879 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
— | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND, USA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
JOHN CONRAD BURK | | 14. MOTHER'S MAIDEN NAME
LYNDE HOMAN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
— | |
| 17. INFORMANT
HENRIETTA MITCHELL | | Address Baltimore 12m 747 McCabe Av | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute AND Chronic Congestive Heart Failure
DUE TO (b) ESSENTIAL HYPERTENSION
DUE TO (c) GENERALIZED ARTERIOSCLEROSIS | | | INTERVAL BETWEEN ONSET AND DEATH
15 YEARS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
NO | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
— | |
| 20c. TIME OF INJURY
Hour a. m. — p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
— | | 20f. (City or town) (County) (State)
— | |
| 21. I certify that (I) (this hospital) attended the deceased from APRIL 15, 1959 to FEB 15, 1962 that (I) (we) last saw the deceased alive on FEB 14, 1962 , and that death occurred at 7:02 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr Henry L McCorkle | | 22b. DATE SIGNED
Feb 15, 1962 | |
| 22c. PHYSICIAN'S NAME (Type)
Henry L. McCorkle MD | | 22d. ADDRESS
Jarrettsville Pike, Phoenix Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Feb 17, 1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St John's Lutheran Church Cemetery | | 23d. LOCATION (City, town, or county) (State)
Sweet Air Phoenix Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Glenn F. Seib | | 25a. REC'D BY REGISTRAR
5209 Vork Rd BALTIMORE MD | |
| 25b. REGISTRAR'S SIGNATURE
Glenn F. Seib | | 25c. DATE
FEB 19 1962 | |

1881

STATE OF OHIO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01645

01628

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE CO. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institutional: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LUTHERVILLE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LUTHERVILLE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
605 GOUCHER AVE. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MEIDA Middle MUSE Last MUSE | | 4. DATE OF DEATH
Month FEBRUARY Day 26 Year 1962 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
APRIL 21, 1878 |
| 9. AGE (In years last birthday)
83 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | |
| 10b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | 11. BIRTHPLACE (County & State, or foreign country)
GEORGIA | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
C.D. ATHON | |
| 14. MOTHER'S MAIDEN NAME
JULIA JOHNSON | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
NO | |
| 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
FAMILY RECORDS | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
260X DUE TO (b) Diabetes mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
15 minutes
7 | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. Month, Day, Year 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from Oct 1, 1962 to Feb 27, 1962 that (2) (we) last saw the deceased alive on Feb 27, 1962 , and that death occurred at 11 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
George T. Gilmore M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
George T. Gilmore, M.D. | | 22d. ADDRESS
Lanham Building Lutherville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
CREMATION | | 23b. DATE THEREOF
2/28/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
GREENMOUNT CREMATORY | | 23d. LOCATION (City, town or county) (State)
BALTIMORE CITY, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John Burns Sons' Lutherville, Md. | | 25a. REC'D BY REGISTRAR
DATE MAR 1 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Hines | | | |

01858

01858



BALTIMORE CO.

WILMINGTON

CONTRACTOR

CONTRACTOR

1000 GUNTER AVE.

1000 GUNTER AVE.

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APRIL 21, 1978

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01646

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01629

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville
c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
405 Winters Lane | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville
d. STREET ADDRESS
405 Winters Lane | | | |
| 3. NAME OF DECEASED (Type or print)
First Hattie Middle Neal Last
4. DATE OF DEATH Month Feb. Day 27 Year 1962 | | | | a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX
Fem | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH
May 9, 1881 | | 9. AGE (In years last birthday) 80 yrs. | | 10. IF UNDER 1 YEAR Months 27 Days 19 | | | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic | | 12. KIND OF BUSINESS OR INDUSTRY
House Work | | 13. BIRTHPLACE (State or foreign country)
Baltimore | | | |
| 14. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 15. FATHER'S NAME
Thomas J. Jackson | | 16. MOTHER'S MAIDEN NAME
Lineda Hollin | | | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No | | 18. SOCIAL SECURITY NO.
? | | 19. INFORMANT Address 43
Anti-Robinson, S. Leallos | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac Failure
(b) Generalized Arterio Sclerosis
(c) Cardio vascular heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Geo. S. M. Kieffer M.D. DATE SIGNED 2-27-62 | | | | | | | |
| EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| Address (Street, city, town, or county) 1010 Leeds Ave | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3/3/62 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | | |
| 22d. LOCATION (City, town, or country)
Balto. Md. | | 23. FUNERAL DIRECTOR ADDRESS
E. O. Wilson 1000 Brantley Ave. | | | | | |
| 24a. REC'D BY REGISTRAR 5 '62 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Knaus | | | | | |

01929

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01929

01929

Baltimore

10

Baltimore

Chesapeake

Chesapeake

105 Avenue Lane

105 Avenue Lane

1901. 17. 1902

Local

Local

to

May 1901

colored

to

U.S.A.

1901. 17. 1902

House York

Domestic

1901. 17. 1902

1901. 17. 1902

1901. 17. 1902

1901. 17. 1902

1901. 17. 1902

1901. 17. 1902

1901. 17. 1902

1901. 17. 1902

1901. 17. 1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|--|---------------------------|--|---|
| 01647 | | 01630 | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - RANDALLSTOWN | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - RANDALLSTOWN | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8714 Church Lane | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MARRIS Middle WAYMAN Last NORRIS | | 4. DATE OF DEATH
Month 2 Day 25 Year 1962 | |
| 5. SEX M | 6. COLOR OR RACE C | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JANUARY 20, 1876 |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR: Months 86 Days 86 Hours 86 Min. 86 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STONE MASON | | 10b. KIND OF BUSINESS OR INDUSTRY STONE MASON | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME OWEN NORRIS | | 14. MOTHER'S MAIDEN NAME REBECCA DAVIS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-05-6889 | |
| 17. INFORMANT Address WIFE - SUSIE NORRIS | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 443 X DEGENERATIVE HEART DISEASE
DUE TO (b) HYPERTENSIVE C.V. DISEASE
DUE TO (c) 15 YEARS | | INTERVAL BETWEEN ONSET AND DEATH 10 YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from JANUARY 15, 1962 to 2/25/62 that (I) we last saw the deceased alive on 2/24/62 and that death occurred at 11 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Edwin L. Pierpont M.D. | | 22b. DATE SIGNED 2/25/62 | |
| 22c. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D. | | 22d. ADDRESS 8204 LIBERTY RD - BALTO. 7, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 3-2-1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY St. Thomas | | 23d. LOCATION (City, town, or county) (State) Randallstown, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Funeral Home ADDRESS 1631 Druid Hill Ave. | | 25a. REC'D BY REGISTRAR FEB 28 '62 | |
| | | 25b. REGISTRAR'S SIGNATURE Carlton S. Kline | |

01210

REPUBLIC OF DENMARK

1965



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CORRECTED (2) 01648 Items 7 & 14, File 9-3114/11/62 cas. 02572

| | | | | | | | |
|--|----------------------------------|--|-----------------------------------|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Wilson, Maryland | | | | c. LENGTH OF STAY IN 1b
27 hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Darlington 12 X 2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Mt. Wilson State Hospital | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Goldie Middle Wilson Last Orr | | | | 4. DATE OF DEATH
Month 2 Day 23 Year 19 62 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> divorced | 8. DATE OF BIRTH
6/1/01 | | 9. AGE (In years lost birthday)
60 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Orr | | | | 14. MOTHER'S MAIDEN NAME
Ester Belle Orr Emma Grist | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
216-23-6089 | | 17. INFORMANT Address
Hospital Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 002.1
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Congestive Cardiac Failure | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/22 1:30 P.M. 2/23/ 19 62 that (I) (we) last saw the deceased alive on 2/23 19 62 , and that death occurred at M , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
W. Newcomer | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2/23/62 | |
| 22c. PHYSICIAN'S NAME (Type)
Wm. Newcomer, M.D., Superintendent | | | | 22d. ADDRESS
Mt. Wilson State Hospital, Mt. Wilson, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/26/62 | | 23c. NAME OF CEMETERY OR CREMATORY
Southern | | 23d. LOCATION (City, town, or county) (State)
Dublin Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John A. Harkins, Delta, Pa. | | | | 25a. REC'D BY REGISTRAR
DATE MAR 8 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

Three for one certificate - Film 8308-3/8/62 JAB.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01649

CERTIFICATE OF DEATH

01631

| | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rossuville</u>
c. LENGTH OF STAY IN 1b <u>20 yrs</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>8729 Philadelphia Road</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Rossuville</u>
d. STREET ADDRESS
<u>8729 Philadelphia Road</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
<u>Clarence</u> | | First <u>E</u> Middle <u>Owens</u> Last
4. DATE OF DEATH
Month <u>2</u> Day <u>22</u> Year <u>19 62</u> | | 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>2-17-1888</u> | | 9. AGE (In years last birthday) <u>74</u> yrs.
IF UNDER 1 YEAR: Months <u>7</u> Days <u>14</u>
IF UNDER 24 HRS.: Hours <u>14</u> Min. <u>15</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Stationary Eng.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Esso Standard Oil</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore Md</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U S A</u> | | | | | |
| 13. FATHER'S NAME
<u>Henry Owens</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Braun</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | | | | |
| 16. SOCIAL SECURITY NO.
<u>212-09-0138</u> | | | | 17. INFORMANT
<u>Mrs Madelon Owens</u> | | | | Address <u>8729 Phila. Rd (6)</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO (c) <u>2 yrs</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u>19</u> p.m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 20, 1962</u> to <u>Feb 22, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 22, 1962</u> and that death occurred at <u>8:30</u> M. from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
<u>W. Brummquidner</u> M.D. | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>2/23/62</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Balto 6 Md</u> | | | | | | 22d. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 23b. DATE THEREOF
<u>2-26-1962</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parkwood Cemetery</u> | | | | 23d. LOCATION (City, town or county) (State)
<u>Baltimore Md.</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Lassahn Funeral Home 7401 Balair Road</u> | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 26 '62</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

VR A15 (4)
15M 7/61

01001

01001

CREAT DATE OF DEATH

for the purpose of the 1900 Census

TO HOSPITAL 28. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01650

01632

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown, Md | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown, Md | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 3 Box 229 | | d. STREET ADDRESS Route 3, Box 229 | |
| 3. NAME OF DECEASED (Type or print) Ethel M. Parrish. | | 4. DATE OF DEATH February 8 1962 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 4, 1895 |
| 9. AGE (In years last birthday) 66 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Harry F. Boyle. | | 14. MOTHER'S MAIDEN NAME Dora Smith. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. Ruth Verbus, Reisterstown, Md. | |
| 17. INFORMANT Ruth Verbus, Reisterstown, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ① Uremia - ② Arteriosclerosis
434.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ③ Nephritis - Chronic
DUE TO ④ Congestive Heart Failure Chronic
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ⑤ 2 years
INTERVAL BETWEEN ONSET AND DEATH ⑥ 2 years
⑦ 2 years
⑧ 2 years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from August 1958 to February 8, 1962 , that (I) (we) last saw the deceased alive on February 7, 1962 , and that death occurred at 5:45 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Clarence E. McWilliams | | 22b. DATE SIGNED February 8, 1962 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS 11904 Reisterstown Rd, Reisterstown, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/12/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park | | 23d. LOCATION (City, town, or county) (State) Windsor Mill Rd, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Austin E. Sonoran-3818 Roland Ave | | 25a. REC'D BY REGISTRAR February 13 '62 | |
| 25b. REGISTRAR'S SIGNATURE William E. Thomas | | | |

01003

RECORD OF CASE

01003

(M)

1003

1003

1003

1003

1003

1003

1003

1003

1003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 2 & 7 Film G307 2/21/62 1wk

CERTIFICATE OF DEATH

01633

Reg. Dist. No.

01651

| | | | |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>SV 01-4</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Reisterstown</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City, Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bent missing Home</u> | | d. STREET ADDRESS <u>1818 N. Payson St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MORTIMER Peters</u> | | 4. DATE OF DEATH Month Day Year <u>2-1-1962</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cal</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>about-65</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salvage</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>In General</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Sylvia Boddie</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u>
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC C.V. DISEASE</u>
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>36 HRS.</u>
<u>YEARS</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ |
| 20f. (City or town) _____ (County) _____ (State) _____ | | 21. I certify that I attended the deceased from <u>1/5</u> , 19 <u>62</u> , to <u>2/1</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>2/1</u> , 19 <u>62</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above. | |
| ACTUAL SIGNATURE <u>Martin E. Strobel</u> M.D. <u>48 MAIN ST.</u> DATE SIGNED <u>2/1/62</u> | | ADDRESS (Street, city or town, state) _____ | |
| PHYSICIAN'S NAME (Type) <u>MARTIN E. STROBEL</u> <u>REISTERSTOWN MD.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>2-3-62</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>mt Calvary Cem</u> | 22d. LOCATION (City, town, or county) (State) <u>Anne Arundel</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u> ADDRESS <u>1800 Bromley Ave</u> | | 24a. REC'D BY REGISTRAR <u>DATE FEB 14 '62</u> | 24b. REGISTRAR'S SIGNATURE <u>Carroll S. [unclear]</u> |

UUU-67-10

MEDICAL CERTIFICATION

01210

© 1951 M. J. J. J. J.

12121



12121-12121



CHIVERTON

[illegible]

2015 11 12

* Ritchie Samuel James Marshall

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01653 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01635

| | | | | | | | |
|---|---|---|---------------------------------------|--|--------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore County MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
North Point | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
North Point | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
4210 Lynhurst Road | | | | d. STREET ADDRESS
4210 Lynhurst Road #22 | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
FLOYD ELLIS POLING | | | | 4. DATE OF DEATH
Month Day Year
February 15 1962 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-16-1936 | 9. AGE (In years last birthday)
25 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Nailer | | 10b. KIND OF BUSINESS OR INDUSTRY
Mfg. Boxes | | 11. BIRTHPLACE (State or foreign country)
West Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Dayton Isaac Poling | | | | 14. MOTHER'S MAIDEN NAME
Ivy May (Nee Poling) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
No | | 16. SOCIAL SECURITY NO.
234-54-2333 | | 17. INFORMANT
Address
Mrs. Elsie V. Poling-4210 Lyndhurst Road- #22 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) (1) Subarachnoid hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (2) Massive pulmonary edema
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
no | | 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
Superficial abrasions of nose
Manner Unknown | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
Unknown 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Unknown | | 20f. (City or town)
Unknown | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Rudiger Breitenecker | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
Rudiger Breitenecker, M.D. | | | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED
February 16, 1962 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | | | 22b. DATE THEREOF
2-18-62 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Payne Cemetery | | | | 22d. LOCATION (City, town, or country) (State)
Thornton West Virginia | | | |
| 23. FUNERAL DIRECTOR
Wm. J. Pickens | | | | 24a. REC'D BY REGISTRAR
DATE FEB 19 '62 | | | |
| ADDRESS
Baltimore Md. | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | |

MEDICAL CERTIFICATION

THE STATE
DEPARTMENT

(M)

(M)

(M)

(M)

(M)

(M)

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01654

01636

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville
c. LENGTH OF STAY IN 1b
23yr7mth24ays
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
1306 Greenmount Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
William
First
Polk
Middle
Polk
Last | | 4. DATE OF DEATH
Month
February
Day
24
Year
19 62 | |
| 5. SEX
male | | 6. COLOR OR RACE
white | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 20, 1899 | |
| 9. AGE (In years last birthday)
62 yrs. | | 10. IF UNDER 1 YEAR
Months
62 Days
24 | |
| 11. IF UNDER 24 HRS.
Hours
62 Min.
24 | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
William Polk | | 14. MOTHER'S MAIDEN NAME
Ella ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
219-01-9152 | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address
SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
241X cardiac failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
Chronic Cardiovascular disease secondary to
(c)
Bronchial Asthma
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
none | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
- | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that it (this hospital) attended the deceased from June 27 , 19 38 to Feb 24 , 19 62 ; that (I) (we) last saw the deceased alive on Feb 24 , 19 62 , and that death occurred at 5:25 P , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Maurice J. Van Besien
M.D. | | 22b. DATE SIGNED
2/26/62 | |
| 22c. PHYSICIAN'S NAME (Type)
MAURICE J. VAN BESIE | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Catonsville 28, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
3-1-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Peters Cemetary | | 23d. LOCATION (City, town or county) (State)
Baltimore | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook, Inc., 1217 St. Paul Street, ZONE 2 | | 25e. REC'D BY REGISTRAR
DATE MAR 1 '62 | |
| 25b. REGISTRAR'S SIGNATURE
G. S. Kraw | | | |

01833

1153



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01655
CERTIFICATE OF DEATH
01637

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fort Howard
c. LENGTH OF STAY IN 1b
56 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
3V01-4
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore 17
d. STREET ADDRESS
540 Robert Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
GEORGE O. PRITCHETT | | 4. DATE OF DEATH
Month Day Year
February 8 19 62 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
December 6, 1891 |
| 9. AGE (In years last birthday)
70 | | 10. IF UNDER 1 YEAR
Months Days
70 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mover | | 12. KIND OF BUSINESS OR INDUSTRY
Transfer Company | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Ella Pritchett | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
217-03-7099 | |
| 17. INFORMANT
Clinical Records, VAH, Baltimore 18, Maryland | | 18. ADDRESS
Fort Howard Division | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GENERALIZED ADENOCARCINOMATOSIS
DUE TO
ADENOCARCINOMA OF STOMACH
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.
(b) SIX
(c) | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN
UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Operation: 1/3/62 - Laparotomy revealed widespread carcinoma from stomach | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m.
19 | | 20d. INJURY OCCURRED
While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 14, 1961 , to February 8, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 8, 1962 , and that death occurred at 5:10 P.M. , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Joseph M. Miller
M.D. | | 22b. DATE SIGNED
2/8/62 | |
| 22c. PHYSICIAN'S NAME (Type)
JOSEPH M. MILLER, M.D.
Chief, Surgical Service | | 22d. ADDRESS
VAH, BALTIMORE 18 MD., FT. HOWARD DIVISION | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Feb. 12, 62 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery Baltimore, Maryland | 23d. LOCATION (City, town or county) (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Arlington S. Phillips | | 25. REC'D BY REGISTRAR
13 '62 | |
| 25. REGISTRAR'S SIGNATURE
Wm. S. Turner | | | |

Md.

CERTIFICATE OF DEATH

Reg. Dist. **01638**

01656

| | | | | | | | |
|--|---------------------------|--|----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY — | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| c. LENGTH OF STAY IN 1b 2 wks. | | | | 3 V01-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7206 River Drive Rd. | | | | d. STREET ADDRESS 3700 E. Lombard St. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE RAMSEL | | | | 4. DATE OF DEATH Month Day Year February 7, 1962 19 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-18-87 | | 9. AGE (In years last birthday) 74 yrs. | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Charwoman | | 10b. KIND OF BUSINESS OR INDUSTRY Balto. City | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ----- Scholl | | | | 14. MOTHER'S MAIDEN NAME Christine | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT | | Address Lee W. Ramsel 7206 River Dr. Rd. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis (6 weeks.)
153.8 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anaplastic Carcinoma, right colon.
DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 weeks.
9 - 12 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from September 15 19 61 to February 4 19 62 that I last saw the deceased alive on February 4, 19 62 , and that death occurred on 6:20 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Michael K. Finegan | | | | ADDRESS (Street, city or town, state) 1202 St. Paul Street -2- | | DATE SIGNED 2/8/62 | |
| PHYSICIAN'S NAME (Type) Michael Kevin Finegan, M. D. | | | | 1202 St. Paul Street -2- | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-12-62 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Baltimore, Md. | | | | 24a. REC'D BY REGISTRAR FEB 13 '62 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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(M)

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01657

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01639

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
rural - Overlea
c. LENGTH OF STAY IN 1b
Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
5001 Hazelwood | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
rural - Overlea
d. STREET ADDRESS
5001 Hazelwood
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
AMELIA M. REINHARDT | | | | 4. DATE OF DEATH
Month Day Year
February 17 19 62 | | | |
| 5. SEX
female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-19-1894 | |
| 9. AGE (In years last birthday)
67 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Houseworker | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U S A | | | | | | | |
| 13. FATHER'S NAME
Andrew Reinhardt | | | | 14. MOTHER'S MAIDEN NAME
Agusta C. Weber | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-32-5299 | | 17. INFORMANT
Address
Mrs George Breger 5001 Hazelwood Ave. (6) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intestinal Obstruction
561 DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Strangulated femoral hernia
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
partial | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
partial | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Charles S. Petty
EXAMINER'S NAME (Type) Charles S. Petty | | | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
2/17/62 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2-20-1962 | | 22c. NAME OF CEMETERY OR CREMATORY
Jerusalem Luth. Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| 23. FUNERAL DIRECTOR
Lassahn Funeral Home 7401 Belen Road
ADDRESS | | | | 24b. REC'D BY REGISTRAR
DATE
FEB 19 '62 | | | |
| | | | | 24d. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
2
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01658

CERTIFICATE OF DEATH

Reg. Dist. No. 01640

| | | | |
|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 Roberts Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Miranda B. Rivers</u> | | 4. DATE OF DEATH <u>Feb. 3, 1962</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Caucasian</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 25, 1887</u> |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>St. Mary's, Ga.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Thomas Butler</u> | | 14. MOTHER'S MAIDEN NAME <u>U.S.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>3 Roberts Ave.</u> | |
| 17. INFORMANT <u>3 Roberts Ave.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Mitral Insufficiency</u>
DUE TO (b) <u>Arterio-sclerotic Heart Disease</u>
DUE TO (c) <u>Hypostatic Pneumonia</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Pneumonia</u> | |
| INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov. 4th, 1961</u> to <u>Feb. 3rd, 1962</u> , that I last saw the deceased alive on <u>Feb. 3rd, 1962</u> , and that death occurred at <u>5:10 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>C. F. Maloney, M.D.</u> | | ADDRESS (Street, city or town, state) <u>57 Winters Lane, Catonsville, 28, Md.</u> | |
| DATE SIGNED <u>2/3/62</u> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 22b. DATE THEREOF <u>2-8-1962</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Balt. Co. Md.</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>1631 Saint Hill Ave.</u> | |
| 24a. REC'D BY REGISTRAR <u>Feb 9 '62</u> | | 24b. REGISTRAR'S SIGNATURE | |

CERTIFICATE OF DEATH

1958

| | | | |
|--|--|---|--|
| 1. NAME OF DECEASED
<i>John Doe</i> | | 2. SEX
<i>Male</i> | |
| 3. AGE
<i>65</i> | | 4. RACE
<i>White</i> | |
| 5. DATE OF BIRTH
<i>Jan 15, 1893</i> | | 6. PLACE OF BIRTH
<i>Baltimore, Md</i> | |
| 7. DATE OF DEATH
<i>Dec 10, 1958</i> | | 8. PLACE OF DEATH
<i>Home</i> | |
| 9. TIME OF DEATH
<i>10:30 AM</i> | | 10. CAUSE OF DEATH
<i>Heart Disease</i> | |
| 11. MANNER OF DEATH
<i>Natural</i> | | 12. SIGNATURE OF PHYSICIAN
<i>Dr. J. Smith</i> | |
| 13. SIGNATURE OF REGISTRAR
<i>John Doe</i> | | 14. SIGNATURE OF WITNESSES
<i>John Doe, Jane Doe</i> | |
| 15. SIGNATURE OF DECEASED
<i>John Doe</i> | | 16. SIGNATURE OF NEXT OF KIN
<i>John Doe</i> | |
| 17. SIGNATURE OF CLERK
<i>John Doe</i> | | 18. SIGNATURE OF JUDGE
<i>John Doe</i> | |
| 19. SIGNATURE OF SHERIFF
<i>John Doe</i> | | 20. SIGNATURE OF DISTRICT ATTORNEY
<i>John Doe</i> | |
| 21. SIGNATURE OF COUNTY CLERK
<i>John Doe</i> | | 22. SIGNATURE OF CITY CLERK
<i>John Doe</i> | |
| 23. SIGNATURE OF STATE CLERK
<i>John Doe</i> | | 24. SIGNATURE OF FEDERAL CLERK
<i>John Doe</i> | |
| 25. SIGNATURE OF MARSHAL
<i>John Doe</i> | | 26. SIGNATURE OF SHERIFF
<i>John Doe</i> | |
| 27. SIGNATURE OF JUDGE
<i>John Doe</i> | | 28. SIGNATURE OF DISTRICT ATTORNEY
<i>John Doe</i> | |
| 29. SIGNATURE OF COUNTY CLERK
<i>John Doe</i> | | 30. SIGNATURE OF CITY CLERK
<i>John Doe</i> | |
| 31. SIGNATURE OF STATE CLERK
<i>John Doe</i> | | 32. SIGNATURE OF FEDERAL CLERK
<i>John Doe</i> | |
| 33. SIGNATURE OF MARSHAL
<i>John Doe</i> | | 34. SIGNATURE OF SHERIFF
<i>John Doe</i> | |
| 35. SIGNATURE OF JUDGE
<i>John Doe</i> | | 36. SIGNATURE OF DISTRICT ATTORNEY
<i>John Doe</i> | |
| 37. SIGNATURE OF COUNTY CLERK
<i>John Doe</i> | | 38. SIGNATURE OF CITY CLERK
<i>John Doe</i> | |
| 39. SIGNATURE OF STATE CLERK
<i>John Doe</i> | | 40. SIGNATURE OF FEDERAL CLERK
<i>John Doe</i> | |
| 41. SIGNATURE OF MARSHAL
<i>John Doe</i> | | 42. SIGNATURE OF SHERIFF
<i>John Doe</i> | |
| 43. SIGNATURE OF JUDGE
<i>John Doe</i> | | 44. SIGNATURE OF DISTRICT ATTORNEY
<i>John Doe</i> | |
| 45. SIGNATURE OF COUNTY CLERK
<i>John Doe</i> | | 46. SIGNATURE OF CITY CLERK
<i>John Doe</i> | |
| 47. SIGNATURE OF STATE CLERK
<i>John Doe</i> | | 48. SIGNATURE OF FEDERAL CLERK
<i>John Doe</i> | |
| 49. SIGNATURE OF MARSHAL
<i>John Doe</i> | | 50. SIGNATURE OF SHERIFF
<i>John Doe</i> | |
| 51. SIGNATURE OF JUDGE
<i>John Doe</i> | | 52. SIGNATURE OF DISTRICT ATTORNEY
<i>John Doe</i> | |
| 53. SIGNATURE OF COUNTY CLERK
<i>John Doe</i> | | 54. SIGNATURE OF CITY CLERK
<i>John Doe</i> | |
| 55. SIGNATURE OF STATE CLERK
<i>John Doe</i> | | 56. SIGNATURE OF FEDERAL CLERK
<i>John Doe</i> | |
| 57. SIGNATURE OF MARSHAL
<i>John Doe</i> | | 58. SIGNATURE OF SHERIFF
<i>John Doe</i> | |
| 59. SIGNATURE OF JUDGE
<i>John Doe</i> | | 60. SIGNATURE OF DISTRICT ATTORNEY
<i>John Doe</i> | |
| 61. SIGNATURE OF COUNTY CLERK
<i>John Doe</i> | | 62. SIGNATURE OF CITY CLERK
<i>John Doe</i> | |
| 63. SIGNATURE OF STATE CLERK
<i>John Doe</i> | | 64. SIGNATURE OF FEDERAL CLERK
<i>John Doe</i> | |
| 65. SIGNATURE OF MARSHAL
<i>John Doe</i> | | 66. SIGNATURE OF SHERIFF
<i>John Doe</i> | |
| 67. SIGNATURE OF JUDGE
<i>John Doe</i> | | 68. SIGNATURE OF DISTRICT ATTORNEY
<i>John Doe</i> | |
| 69. SIGNATURE OF COUNTY CLERK
<i>John Doe</i> | | 70. SIGNATURE OF CITY CLERK
<i>John Doe</i> | |
| 71. SIGNATURE OF STATE CLERK
<i>John Doe</i> | | 72. SIGNATURE OF FEDERAL CLERK
<i>John Doe</i> | |
| 73. SIGNATURE OF MARSHAL
<i>John Doe</i> | | 74. SIGNATURE OF SHERIFF
<i>John Doe</i> | |
| 75. SIGNATURE OF JUDGE
<i>John Doe</i> | | 76. SIGNATURE OF DISTRICT ATTORNEY
<i>John Doe</i> | |
| 77. SIGNATURE OF COUNTY CLERK
<i>John Doe</i> | | 78. SIGNATURE OF CITY CLERK
<i>John Doe</i> | |
| 79. SIGNATURE OF STATE CLERK
<i>John Doe</i> | | 80. SIGNATURE OF FEDERAL CLERK
<i>John Doe</i> | |
| 81. SIGNATURE OF MARSHAL
<i>John Doe</i> | | 82. SIGNATURE OF SHERIFF
<i>John Doe</i> | |
| 83. SIGNATURE OF JUDGE
<i>John Doe</i> | | 84. SIGNATURE OF DISTRICT ATTORNEY
<i>John Doe</i> | |
| 85. SIGNATURE OF COUNTY CLERK
<i>John Doe</i> | | 86. SIGNATURE OF CITY CLERK
<i>John Doe</i> | |
| 87. SIGNATURE OF STATE CLERK
<i>John Doe</i> | | 88. SIGNATURE OF FEDERAL CLERK
<i>John Doe</i> | |
| 89. SIGNATURE OF MARSHAL
<i>John Doe</i> | | 90. SIGNATURE OF SHERIFF
<i>John Doe</i> | |
| 91. SIGNATURE OF JUDGE
<i>John Doe</i> | | 92. SIGNATURE OF DISTRICT ATTORNEY
<i>John Doe</i> | |
| 93. SIGNATURE OF COUNTY CLERK
<i>John Doe</i> | | 94. SIGNATURE OF CITY CLERK
<i>John Doe</i> | |
| 95. SIGNATURE OF STATE CLERK
<i>John Doe</i> | | 96. SIGNATURE OF FEDERAL CLERK
<i>John Doe</i> | |
| 97. SIGNATURE OF MARSHAL
<i>John Doe</i> | | 98. SIGNATURE OF SHERIFF
<i>John Doe</i> | |
| 99. SIGNATURE OF JUDGE
<i>John Doe</i> | | 100. SIGNATURE OF DISTRICT ATTORNEY
<i>John Doe</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01659

CERTIFICATE OF DEATH

Item 7 Film G307 2/16/62 lwk

01641

| | | | | | |
|--|---|---|--|--|---|
| 1. PLACE OF DEATH
e. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
e. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville
d. STREET ADDRESS
100 Newburg Ave.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
John Robb | | | 4. DATE OF DEATH
Month Day Year
February 9, 1962 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
November 4, 1876 | 9. AGE (In years last birthday)
85 yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Merchant-Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Hardware | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. |
| 13. FATHER'S NAME
William W. Robb | | | 14. MOTHER'S MAIDEN NAME
Catherine Jann | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
215-03-6698 | | 17. INFORMANT
Mrs May Whittington
Address
100 Newburg Ave, Catonsville | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Carcinoma of prostate with metastases
177X DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour e.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1962 , to Feb 9, 1962 that (I) (we) last saw the deceased alive on Feb 5, 1962 , and that death occurred at 9:45 AM , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
John A. Nesbitt, Jr. | | 22b. DATE SIGNED
2-12-62 | 22c. PHYSICIAN'S NAME (Type)
JOHN A. NESBITT, JR | | |
| 22d. ADDRESS
1118 St Paul St. Balto 2 Md | | 22e. REC'D BY REGISTRAR
DATE FEB 13 '62 | | | |
| 22f. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | 23. LOCATION (City, town or county) (State)
Baltimore Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-12-1962 | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John A. Nesbitt, Jr. | | ADDRESS
Catonsville-28-Md | | 25. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01642

01650

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1927 Dundalk Ave. # 22 | | | | d. STREET ADDRESS
1927 Dundalk Ave. # 22. | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First ALICE Middle M. Last ROCKSTROH. | | | | 4. DATE OF DEATH
Month February Day 10, Year 19 62. | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 19, 1906 | |
| 9. AGE (In years lost birthday)
55 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Work | | | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home. | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
? Kurtz | | | | 14. MOTHER'S MAIDEN NAME
Caroline ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
213-12-0701 | | | |
| 17. INFORMANT
John W. Rockstroh | | | | Address
Same. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH
151X DUE TO WITH METASTASES
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
8 MONTH | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from July , 19 61 , to 2/10/62 , that I last saw the deceased alive on 2/5/62 , 19 62 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 3401 Dundalk Ave. Ba. Co. Md. DATE SIGNED 2/12/62
ACTUAL SIGNATURE W. E. Baermann M.D.
PHYSICIAN'S NAME (Type) W. E. Baermann, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2- 13 -62 | | 22c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 22d. LOCATION (City, town, or county) (State)
7225 Eastern Blvd. Ba. Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles S. Galer | | | | ADDRESS
6224 Eastern Ave. Balto., Md. | | 24a. REC'D BY REGISTRAR
DATE FEB 13 '62 | |
| 24b. REGISTRAR'S SIGNATURE
Charles S. Galer | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3833 Arbutus Ave. | | d. STREET ADDRESS 3833 Arbutus Ave. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last SARAH ROLL | | 4. DATE OF DEATH Month Day Year 2/14/62 19 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 30, 1884 |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Abraham Katz | | 14. MOTHER'S MAIDEN NAME Goldie ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Esther R. Nicolaus - Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO HASCVI
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 5 min | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 57, Feb. 14, 1962 that I lost saw the deceased alive on Feb. 14, 1962 and that death occurred at 360 Lochowen Dr - 7 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Daniel Bakal | | DATE SIGNED 15 Feb 62 | |
| PHYSICIAN'S NAME (Type) Daniel Bakal | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2/16/62 | |
| 22c. NAME OF CEMETERY OR CREMATORY Maryland Lodge | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC. ADDRESS 6010 Reist Rd | | 24a. REC'D BY REGISTRAR FEB 20 '62 DATE | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hanes | |

OFFICIAL STATE OF MARYLAND

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CERTIFICATE OF DEATH

Reg. 01644

01662

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|--|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>3011 FAIRVIEW ROAD</u> | | | | d. STREET ADDRESS
<u>3011 FAIRVIEW ROAD</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>ESTHER</u> Middle <u>ROSENBLATT</u> Last | | | | 4. DATE OF DEATH
Month <u>FEB</u> Day <u>28</u> Year <u>1962</u> | | | |
| 5. SEX
<u>FEMALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>JUNE 26, 1914</u> | |
| 9. AGE (In years lost birthday)
<u>47</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSE WIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>BALTO. MD</u> | | 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>SOLOMON</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>LOTTIE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>INFORMANT</u>
<u>EMANUEL ROSENBLATT - SAME</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RHEUMATIC HEART DISEASE.</u>
416X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>35 yrs.</u>
<u>2 yrs.</u> |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>JUN 12, 1925</u> to <u>FEB 28, 1962</u> that I last saw the deceased alive on <u>FEB 28, 1962</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Joseph C. Matchar</u> | | | | ADDRESS (Street, city or town, state)
<u>6821 Buxton Rd, Baltimore</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>JOSEPH C. MATCHAR</u> | | | | DATE SIGNED
<u>FEB 28, 1962</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>3-1-1962</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>WASHINGTON RD</u> | | 22d. LOCATION (City, town, or county) (State)
<u>BALTO. MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Jack Levens Inc.</u> | | | | ADDRESS
<u>2100 Eutaw Place</u> | | 24a. REC'D BY REGISTRAR
DATE <u>MAR 1 '62</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Charles S. Flann</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01663

CERTIFICATE OF DEATH

Reg. Dist. No.

01645

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Dundalk</u> | | c. LENGTH OF STAY IN 1b
<u>8 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Dundalk</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>1935 Searles Road</u> | | | | d. STREET ADDRESS
<u>1935 Searles Road</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>MAE</u> Middle <u>V</u> Last <u>ROUTZAHN</u> | | | | 4. DATE OF DEATH
Month <u>February</u> Day <u>3</u> Year <u>1962</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>3-7-1906</u> | |
| 9. AGE (In years last birthday)
<u>55</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Crosse & Blackwell</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>&, Goldenbergs</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Otha Shoemaker</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>no</u>
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>216-24-3391</u> | | 17. INFORMANT
<u>Mrs. Gloria Sheridan</u> Address <u>(Above)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
420.1 DUE TO <u>hypertensive CVD</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>diabetes mellitus</u>
(b) <u> </u> (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 min.</u>
<u>5 yrs.</u>
<u>4 yrs.</u> | |
| | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>66</u> , to <u>Feb 3</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Feb 3</u> , 19 <u>62</u> , and that death occurred at <u>7A</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Burton V. Lock M.D.</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>2936 E. Baltimore St.</u> DATE SIGNED <u> </u> | | | |
| PHYSICIAN'S NAME (Type) <u>Burton V. Lock</u> | | | | <u>Baltimore, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>2-7-1962</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Oak Lawn</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Eastern Blvd. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>JOHN J. DUDA</u> ADDRESS <u>7922 Wise Ave. 22, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>FEB 6 '62</u> | | 24b. REGISTRAR'S SIGNATURE
<u>C. S. Kinn</u> | |

CERTIFICATE OF DEATH

Reg. Dist. No. **Q1664**

| | | | |
|--|---------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Balto MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE md b. COUNTY — | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bella Nova | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto md | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clayburg Home | | d. STREET ADDRESS 3054 Beuphign St | |
| 3. NAME OF DECEASED (Type or print) Sarah O Rueckert First Middle Last | | 4. DATE OF DEATH Feb. 2 Month Day Year 1962 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 9 1870 91 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Rev. Wm Sommer | | 14. MOTHER'S MAIDEN NAME Emilie Pietzsche | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. — | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 480X 11 Broncho - Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (2) - Gynpne - (Virus)
DUE TO (c) (3) - Arterio - Sclerotic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH
3 days
5 days
5 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio - Sclerosis | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 19 56 , to Feb. 2 19 62 that I last saw the deceased alive on Feb. 2 19 62 , and that death occurred at 12:30 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Earl L. Chambers | | ADDRESS (Street, city or town, state) 4108 Blunt Pltys Cn Baltimore | |
| PHYSICIAN'S NAME (Type) Earl L. Chambers | | DATE SIGNED 2-3-62 | |
| 22a. BURIAL CREMATORY (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| Burial Feb 62 | Feb 62 | St. Pauls Cemetery | Nototable md |
| 23. FUNERAL DIRECTOR'S SIGNATURE PA Germany | | ADDRESS 6067 Hayford Rd | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| DATE FEB 8 '62 | | Arthur L. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK

OFFICE

OFFICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
e. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
e. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X CATONSVILLE</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>7 RIDGE RD.</u> | | d. STREET ADDRESS
<u>7 RIDGE RD.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>JOSEPH</u> Middle <u>RUSH</u> Last <u>RUSH</u> | | 4. DATE OF DEATH
Month <u>FEB.</u> Day <u>7</u> Year <u>1962</u> | |
| 5. SEX
<u>M.</u> | 6. COLOR OR RACE
<u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>AUG. 27, 1892</u> |
| 9. AGE (In years last birthday)
<u>69</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED NIGHT SUPERVISOR, DUNKEE ENT.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>MD.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>CHARLES RUSH</u> | | 14. MOTHER'S MAIDEN NAME
<u>KUNICUNDA</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<u>No.</u> | | 16. SOCIAL SECURITY NO.
<u>216-05-3106</u> | |
| 17. INFORMANT
<u>MRS MARIE PARR, 7, RIDGE RD. #28</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>
527 } DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u>
DUE TO (c) <u>Chronic Emphysema</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
<u>1 wks.</u>
<u>1 m.</u>
<u>6 m.</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10-18-</u> <u>1955</u> to <u>2-7-</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>2-6-</u> <u>1962</u> and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Wilmer K. Gallagher</u> M.D. | | 22b. DATE SIGNED
<u>2-8-62</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Wilmer K. Gallagher MD</u> | | 22d. ADDRESS
<u>6309 Frederick Ave. Balt. 28, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>FEB 10 1962</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>LOUDON PARK CEMT</u> | 23d. LOCATION (City, town or county) (State)
<u>BALTO. MD.</u> |
| 24 FUNERAL DIRECTOR'S SIGNATURE
<u>WITZKE, 4101 EDMONDSON AVE.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 9 '62</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thomas</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
e. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Dundalk
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
2614 Liberty Parkway | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Dundalk
d. STREET ADDRESS
2614 Liberty Parkway
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
BERTHA RUTH | | 4. DATE OF DEATH
Month Day Year
February 19, 1962 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 16, 1893 |
| 9. AGE (In years last birthday)
68 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
at home | | 11b. KIND OF BUSINESS OR INDUSTRY | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
George Kelch | |
| 14. MOTHER'S MAIDEN NAME
Elizabeth Schumacher | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
Mrs. Anna Kleiner, 2614 Liberty Pkwy., Balto. 22 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
260 DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
DUE TO (b)
arteriosclerotic, cardio-vascular disease
DUE TO (c)
diabetes mellitus | | INTERVAL BETWEEN ONSET AND DEATH
1 1/2 mos.
20 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour e.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 17, 1961 to Feb 19, 1962 that (I) (we) last saw the deceased alive on Feb 17, 1962 and that death occurred at 12:30 P. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
David H. Andrew M.D. | | 22b. DATE SIGNED
2/21/62 | |
| 22c. PHYSICIAN'S NAME (Type)
David Andrew, M.D. | | 22d. ADDRESS
Dundalk Ave. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | 23b. DATE THEREOF
2-22-62 | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | 23d. LOCATION (City, town or county) (State)
Baltimore County, Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Ullrich Funeral Home, Dundalk, Md. | | 25a. REC'D BY REGISTRAR
DATE FEB 23 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | |

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CONFIDENTIAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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Item 13 Film G308 3/12/62 iwk

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| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN 1b 10 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 6500 Hartwait Street
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First FRANCIS Middle R. Last RUTH | | 4. DATE OF DEATH
Month February Day 26 Year 1962 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 20, 1906 |
| 9. AGE (In years last birthday) 55 yrs. | | 10. IF UNDER 1 YEAR
Months 5 Days 26 | 11. IF UNDER 24 HRS.
Hours 55 Min. 26 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Brewery | |
| 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Henry Ruth | | 14. MOTHER'S MAIDEN NAME Anna Merkins | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW II | | 16. SOCIAL SECURITY NO. 218-09-9312 | |
| 17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland | | Address Fort Howard Division | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION WITH INTRAMURAL THROMBOSIS
DUE TO 420
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1. Multiple Pulmonary Emboli and Pulmonary Infarct. 2. Left hemothorax due to rupture, left innominate vein. - Duration several hours
DUE TO SEV. DAYS
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Multiple Pulmonary Emboli and Pulmonary Infarct. 2. Left hemothorax due to rupture, left innominate vein. - Duration several hours | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from February 16, 1962 to February 26, 1962 that (X) (we) last saw the deceased alive on February 26, 1962 , and that death occurred at 1:20 PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Sebastian Russo
M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D. | | 22b. DATE SIGNED 2/26/62 | |
| 22d. ADDRESS VAH, BALTO 18, MD FT HOWARD, MD. DIVISION | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF MARCH 2, 1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Matthews Funeral Home | | 25a. REC'D BY REGISTRAR DATE MAR 5 '62 | |
| ADDRESS 3021 Eastern Avenue Baltimore 24, Md. | | 25b. REGISTRAR'S SIGNATURE William S. Thomas | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01668

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01650

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALDWIN | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALDWIN | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS MANOR ROAD | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Henry Middle John Last Sadler, JR | | 4. DATE OF DEATH
Month FEBRUARY Day 9 Year 1962 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 12, 1961 |
| 9. AGE (In years lost birthday) — yrs. | | IF UNDER 1 YEAR
Months 3 Days 29 Hours 1 Min. 8 | IF UNDER 24 HRS.
Hours 1 Min. 8 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Henry John Sadler | | 14. MOTHER'S MAIDEN NAME Dorothy Elizabeth Appel | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT Mr. Henry J. Sadler Address Manor Road Baldwin Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 087X DUE TO Bullous varicella
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO —
(c) — DUE TO —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE.
INTERVAL BETWEEN ONSET AND DEATH 7 days. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. — p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from Feb. 7 19 62 to Feb. 9 19 62 , that (I) (we) lost saw the deceased alive on Feb. 7 19 62 , and that death occurred at 4 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE William A. Andersen M.D. | | 22b. DATE SIGNED Feb. 9, 1962 | |
| 22c. PHYSICIAN'S NAME (Type) WILLIAM A. ANDERSEN M.D. | | 22d. ADDRESS 1528 York Rd. Lutherville Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 2/10/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem | | 23d. LOCATION (City, town, or county) (State) BALTIMORE MD | |
| 24. FUNERAL DIRECTOR'S SIGNATURE L J Ruck ADDRESS 5305 HARFORD RD. | | 25a. REC'D BY REGISTRAR DATE FEB 13 '62 | |
| 25b. REGISTRAR'S SIGNATURE Carlton L. Kline | | | |

2039312342

61-30997

01630

CERTIFICATE OF DEATH

01682



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|------------------|---|--|---|--|---|---|------------------|---|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | |
| 01669 | | | | | 01651 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | | |
| a. COUNTY | | Baltimore | | | a. STATE | | Maryland | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Middle River #20 | | | b. COUNTY | | Baltimore | | |
| c. LENGTH OF STAY IN 1b | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Middle River #20 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 4 Blister St. | | | d. STREET ADDRESS | | 4 Blister St. | | |
| e. IS RESIDENCE ON A FARM? | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED | | | | | 4. DATE OF DEATH | | | | |
| (Type or print) | | First Middle Last | | | Month | | Day | | Year |
| William James Scherer | | | | | February 16, | | | | 19 62 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | White | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | February 5, 1895 | | 67 yrs. | Months | Days | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Tool Crib Attend. | | Aircraft | | Penna. | | USA | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| ? | | | | ? | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| No | | --- | | 196 031100 | | Elsie Scherer | | Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 <i>Coronary occlusion</i> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>Arteriosclerotic cardiovascular disease</i> | | | | | | | | | |
| (c) <i>2 year</i> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Emphysema, asthma</i> | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1950 to Feb 16, 1962, that (I) (we) last saw the deceased alive on Feb 16 1962, and that death occurred at 7 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <i>Louis Semenovoff</i> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type) LOUIS SEMENOFF | | | | | 22d. ADDRESS 2108 Owens Rd, Baltimore 20, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | | | |
| Burial | | 2/19/62 | | Meadowridge Mem. Park | | Elkridge, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>James E. Bruzdinski</i> | | | | | ADDRESS 1407 Eastern Ave. | | 25a. REC'D BY REGISTRAR DATE FEB 19 '62 | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> |

01831

TESTIMONIAL DATA

01831

(M)

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "TESTIMONIAL" and "DATA" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01670
CERTIFICATE OF DEATH
01652

| | | | | | | | |
|---|-------------------------------|---|--------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>503 Goucher Boulevard</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>
d. STREET ADDRESS <u>503 Goucher Boulevard</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Raymond A.</u> | | First <u>A.</u> Middle <u>Schneid</u> Last <u>Schneid</u> | | 4. DATE OF DEATH
Month <u>February</u> Day <u>17</u> Year <u>1962</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 9, 1891</u> | 9. AGE (In years last birthday) <u>70</u> yrs. | IF UNDER 1 YEAR
Months <u>70</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Mor.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Crucible Steel Co</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>John Schneid</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Theiss</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes give war or dates of service)</u> | | 16. SOCIAL SECURITY NO. <u>234-07-6086</u> | | 17. INFORMANT <u>Mrs. Mary Schneid</u> Address <u>503 Goucher Blvd.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Coronary artery Disease</u>
(c) <u>6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>30 min</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | | | |
| 21. I certify that (1) (this hospital) attended the deceased from <u>July</u> 19 <u>57</u> to <u>Feb 17</u> 19 <u>62</u> , that (1) (we) last saw the deceased alive on <u>Feb 17</u> 19 <u>62</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>George T. Gilmore</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>2/19/62</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>George T. Gilmore, M.D.</u> | | 22d. ADDRESS <u>Lanham Building Lutherville, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>2/20/62</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u> | | | |
| 23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u> | | 23e. (State) | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> | | ADDRESS <u>5305 Harford Road #14</u> | | 25e. REC'D BY REGISTRAR <u>FEB 21 '62</u> | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u> | | 25c. (City, town or county) | | | | | |

01625

01625



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01671 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01653

| | | | | | | | |
|--|-------------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE Md b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lansdowne | | c. LENGTH OF STAY IN 1b
X Lansdowne | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
627 Washington Ave | | | | d. STREET ADDRESS
627 Washington Ave | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Pauline L Middle Schultz Last Schultz | | | | 4. DATE OF DEATH
Month Feb. Day 17 Year 1962 | | | |
| 5. SEX
Fem. | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 24, 1885 | 9. AGE (In years last birthday)
76 yrs. | IF UNDER 1 YEAR
Months 7 Days 19 | IF UNDER 24 HRS.
Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Home duties | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (State or foreign country)
Md | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
James Murphy | | | | 14. MOTHER'S MAIDEN NAME
Anna Louise | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
no | | 17. INFORMANT
Robert Cornelius P. Schulte | | Address
Sonoma | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute heart failure
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Hypertensive cardo vascular disease
DUE TO
(c) Generalized arterio sclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a.m. 19
p.m. | Month, Day, Year | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
DATE SIGNED Feb. 17, 62
Address (Street, city, town, or county) 1010 Leeds Ave | | | | | | | |
| ACTUAL SIGNATURE
Geo. S. M. Kieffer | | M.D. | | | | | |
| EXAMINER'S NAME (Type)
Geo. S. M. Kieffer M.D. | | Address (Street, city, town, or county) | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
2-21-62 | 22c. NAME OF CEMETERY OR CREMATORY
Lorraine | | 22d. LOCATION (City, town, or country) (State)
Woodlawn, Maryland | | | |
| 23. FUNERAL DIRECTOR
Fred A. Cole | | | | 24a. REC'D BY REGISTRAR
DATE FEB 20 '62 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

MEDICAL CERTIFICATION



01663

Salisbury

Landmark

627 Washington Ave

Building 2

For. Mite

Home Office

Home

Dec. 2, 1937

To

Feb. 17, 1938

James Murphy
1000 Madison Ave
New York City

Home Office

Representative cargo vessel

Generalized cargo vessel

W. B. Miller

Dec. 2, 1937

1000 Madison Ave

New York City

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 119 Dublin Drive | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville
d. STREET ADDRESS 119 Dublin Drive
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MARION
First Middle Last
M. SIMMONS | | 4. DATE OF DEATH Feb. 16, 1962
Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 25, 1890 |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10b. KIND OF BUSINESS OR INDUSTRY Shirt making | 11. BIRTHPLACE (County & State, or foreign country) Virginia |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown | |
| 14. MOTHER'S MAIDEN NAME unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No | |
| 16. SOCIAL SECURITY NO. 215-05-5611 | | 17. INFORMANT John J. McKenney-119 Dublin Dr. Lutherville
Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LYMPHO-SARCOMATOSIS, GENERALIZED
200-1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 3 1/2 YEARS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 6/23/58 to 2/16/62 , that (I) (we) last saw the deceased alive on 2/15/62 , and that death occurred 8:42 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE T. C. Siwinski
M.D. | | 22b. DATE SIGNED 2/17/62 | |
| 22c. PHYSICIAN'S NAME (Type) T. C. Siwinski, M.D. | | 22d. ADDRESS 206 W. Pennsylvania Avenue, Towson 4, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 2/20/62 | 23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem. | 23d. LOCATION (City, town or county) (State) Baltimore, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. York Rd. Towson, Md. | | 25a. REC'D BY REGISTRAR FEB 20 '62
DATE | |
| 25b. REGISTRAR'S SIGNATURE Arthur L. Hanes | | | |

01054

01075

Baltimore

Maryland

Baltimore

(M)

Luttrellville

Luttrellville

119 Dublin Drive

119 Dublin Drive

Feb. 16, 1962

SIMMONS

M.

MARION

VI

May 25, 1960

X

Female White

USA

Virginia

White Marking

Seawater

(L)

Unknown

Unknown

215-05-5411 John J. Kennedy-119 Dublin Dr. - 4-11-62

NO

Baltimore, Maryland

Baltimore National Cem.

2/20/62

Initial

Wm Cook-Townson, Inc. York Rd. Towson, Md.

CERTIFICATE OF DEATH

Reg. Dist. **01655**

01673

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-White Hall | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-White Hall | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stablersville Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First William Middle Slade Last Six | | 4. DATE OF DEATH
Month February Day 25 Year 1962 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 23, 1875 |
| 9. AGE (In years last birthday) 86 yrs. | | 10. IF UNDER 1 YEAR: Months 8 Days 6 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith | | 10b. KIND OF BUSINESS OR INDUSTRY Blacksmithing | |
| 11. BIRTHPLACE (State or foreign country) White Hall, Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Jeremiah Six | | 14. MOTHER'S MAIDEN NAME Jane Wilson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Elizabeth Six, White Hall, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Vascular disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19
p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1950 to Feb. 25, 1962 , that I last saw the deceased alive on Feb. 25, 1962 , and that death occurred at 8:30 P. M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE A. M. France | | ADDRESS (Street, city or town, state) PARKTON, MD. DATE SIGNED 2/27/62 | |
| PHYSICIAN'S NAME (Type) A. M. FRANCE | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Febr. 27, 1962 | 22c. NAME OF CEMETERY OR CREMATORY Stablersville Cemetery | 22d. LOCATION (City, town, or county) (State) Parkton, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jacob Hartenstein, New Freedom, Pa. | | 24a. REC'D BY REGISTRAR DATE MAR 1 '62 | |
| | | 24b. REGISTRAR'S SIGNATURE William S. France | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01625

CERTIFICATE OF DEATH

01625

(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01674

01656

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
e. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
e. STATE <u>Maryland</u> b. COUNTY <u>-</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b
<u>3yr 1mth 2dys</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>SPRING GROVE STATE HOSPITAL</u> | | d. STREET ADDRESS
<u>4534 Manor View Road</u> | |
| 3. NAME OF DECEASED
(Type or print)
<u>George James Smith</u> | | 4. DATE OF DEATH
Month <u>February</u> Day <u>21</u> Year <u>19 62</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 21, 1892</u> |
| 9. AGE (In years last birthday)
<u>69</u> yrs. | | IF UNDER 1 YEAR
Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>paper hanger</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Sam Dunner</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.</u> | |
| 13. FATHER'S NAME
<u>John Smith</u> | | 14. MOTHER'S MAIDEN NAME
<u>May Ogle</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<u>unknown</u> | | 16. SOCIAL SECURITY NO.
<u>215-07-0996</u> | |
| 17. INFORMANT
<u>Records: SPRING GROVE STATE HOSPITAL</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bilateral pneumonia</u>
490X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour e.m. <u>19</u>
p.m. <u>-</u> | 20d. INJURY OCCURRED
While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Jan. 19 19 59</u> to <u>Feb. 21, 19 62</u> that (I) (we) last saw the deceased alive on <u>Feb. 21, 19 62</u> and that death occurred at <u>11:45</u> M, from the causes and on the date stated above. | | | |
| 22e. SIGNATURE
<u>Stella Wachslar</u> | | 22b. DATE SIGNED
<u>2-21-62</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Stella Wachslar, M. D.</u> | | 22d. ADDRESS
<u>SPRING GROVE STATE HOSPITAL</u>
<u>Catonsville 28, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>2/24/62</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer Cem.</u> | 23d. LOCATION (City, town or county) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles E. Schimunek</u> | | 25e. REC'D BY REGISTRAR
DATE <u>FEB 23 '62</u> | |
| ADDRESS
<u>3331 Brehms Lane</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kline</u> | |

01658

1974

M

1



3531 Stearns Lane
Clayton, N. Carolina 28520
C/25/95

John Stearns, Jr.

Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01675

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01657

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|--|------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Edgemere | | c. LENGTH OF STAY IN 1b
X Edgemere | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
2507 Sycamore Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Phillip Middle J. Last Smith | | 4. DATE OF DEATH
Month Feb. Day 1 Year 19 62 | |
| 5. SEX
Male | 6. COLOR OR RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 26, 1906 |
| 9. AGE (In years last birthday)
55 yrs. | | IF UNDER 1 YEAR
Months 55 Days 55 Hours 55 Min. 55 | IF UNDER 24 HRS.
Months 55 Days 55 Hours 55 Min. 55 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Steel Worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Bethlehem Steel Co., Powhatan Co., Va. | |
| 11. BIRTHPLACE (State or foreign country)
U. S. A. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Ben Smith | | 14. MOTHER'S MAIDEN NAME
Mary Nash | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
213-07-8182 | |
| 17. INFORMANT
Mary Brown - 1007 1/2 N. 5th St., Richmond, Va. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) H-S-C-V-Disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Alcoholism | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour 19 a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
M.B. Davis | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
M.B. DAVIS M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
2/2/62 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
2-5-62 | 22c. NAME OF CEMETERY OR CREMATORY
Center Union Cemetery | 22d. LOCATION (City, town, or county) (State)
Sunnyside, Cumberland Co., Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles R. Law - 802 Madison Ave., Balto., Md. | | ADDRESS | |
| 24a. REC'D BY REGISTRAR
FEB 5 '62 | | 24b. REGISTRAR'S SIGNATURE
Charles R. Law | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01676

01658

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>CLen ARM</u> | | c. LENGTH OF STAY IN 1b
<u>15 years</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>AT Home - Long Green PIKE</u> | | e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>X CLen ARM</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Vernon Lylvan Smith SR</u> | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>1</u> Year <u>1962</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept 6 1925</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Dairy Farm</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>LYLVAN J Smith</u> | | 14. MOTHER'S MAIDEN NAME
<u>IDA Wisnom</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>212-20-0711</u> | |
| 17. INFORMANT
<u>MARY S Smith</u> | | Address
<u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hodgkins</u>
201X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
(c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 yrs. +</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec.</u> 19 <u>61</u> to <u>Feb.</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Jan. 26</u> 19 <u>62</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>William A. Tyson</u> | | 22b. DATE SIGNED
<u>2-1-62</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BORIAL</u> | | 23b. DATE THEREOF
<u>Feb 5/1962</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Wauhs Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>CLen ARM MD</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>C. F. EVANS + Son</u> | | 25a. REC'D BY REGISTRAR
<u>Arthur L. Harris</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>8802 HARFORD RD</u> | | DATE <u>FEB 5 '62</u> | |

(M)

(1)

0575

Ballroom

Class Room

Library

At these two places

Long Green P.K.

23

Sept 2 1932 32

Long Green P.K.

Football

John J. Smith

194

Wichita

and to our May 2 2nd

2nd

1932

1932

1932

1932

1932

1932

C. F. Evans 1932 2nd 2nd

Class Room

01058

0575

1932

Class Room

Long Green P.K.

23

2nd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01639
01677
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
e. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | | c. LENGTH OF STAY IN 1b
1mthl1dys | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS
4511 Beechwood Road | | | |
| 3. NAME OF DECEASED (Type or print)
First Edward Middle Nelson Last Snouffer | | | | 4. DATE OF DEATH
Month February Day 15 Year 1962 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 31, 1905 | |
| 9. AGE (In years last birthday)
56 yrs. | | IF UNDER 1 YEAR
Months 56 Days 56 | | IF UNDER 24 HRS.
Hours 56 Min. 56 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
salesman | | | | 10b. KIND OF BUSINESS OR INDUSTRY
real estate | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. | | | | | | | |
| 13. FATHER'S NAME
Nelson E. Snouffer | | | | 14. MOTHER'S MAIDEN NAME
Ruth Myers | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
none | | | | 16. SOCIAL SECURITY NO.
213-10-7045 | | | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Termina pneumonia
DUE TO 5270
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO Atelectasis of the lung
(c) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes mellitus | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. 19
p.m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
19 | | | | 20g. (County)
19 | | 20h. (State)
19 | |
| 21. I certify that 10 (this hospital) attended the deceased from Jan. 4 1962 to Feb. 15 1962 , that 11 (we) last saw the deceased alive on Feb. 15 1962 , and that death occurred at 11:55 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Stella Wachslar | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS
SPRING GROVE STATE HOSPITAL | | 22b. DATE SIGNED
2-16-62 | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachslar, M. D. | | | | 22e. LOCATION (City, town or county) (State)
Catonsville 28, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Feb 19, 1962 | | 23c. NAME OF CEMETERY OR CREMATOR
Mt Olivet Cemetery | | 23d. LOCATION (City, town or county) (State)
Frederick, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
3 Sarah's Son Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR
DATE FEB 19 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kline | |

01550

01550



213-16-1045

Feb 18, 1962, Mc Oliver Cemetery

Charles Lee Mc Oliver

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01678 CERTIFICATE OF DEATH 01660

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Essex #21 | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
303 Margaret Ave. | | | | d. STREET ADDRESS
303 Margaret Ave. | | | |
| 3. NAME OF DECEASED (Type or print)
First Nicholas Middle Stefan Last | | | | 4. DATE OF DEATH
Month February Day 16 Year 19 62 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
February 9, 1908 | |
| 9. AGE (In years lost birthday)
54 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Foreman | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Fence Co. | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
Martin Stefan | | | | 14. MOTHER'S MAIDEN NAME
Susanna Till | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
213-03-1428 | | 17. INFORMANT
Magadlena Stefan | | Address
Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of Pancreas
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
2 months | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1962 , to Feb 13 1962 , that (I) (we) last saw the deceased alive on Feb 13 1962 , and that death occurred at 12:18 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Robert J. Lyden | | | | 22b. DATE SIGNED
2/17/62 | | | |
| 22c. PHYSICIAN'S NAME (Type)
ROBERT J. LYDEN | | | | 22d. ADDRESS
815 EASTERN AVE BALT 21, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/20/62 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City, town, or county) (State)
Balto Co. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
James E. Bruzdziński | | | | 25a. REC'D BY REGISTRAR
DATE FEB 19 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. House | |

1933

CERTIFICATE OF DEATH

1933

(M)

303 Madison Ave.

303 Madison Ave.

100 Madison Ave.

100 Madison Ave.

100 Madison Ave.

100 Madison Ave.

100

100 Madison Ave.

100 Madison Ave.

100 Madison Ave.

100 Madison Ave.

100 Madison Ave.

100 Madison Ave.

Curry & Associates

CHIEF

MADE

for file

file 12

file 12

100 Madison Ave.

100 Madison Ave.

100 Madison Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01679 CERTIFICATE OF DEATH 01661

| | | | | | | | |
|---|------------------------------|---|-----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X CATONSVILLE</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>HOUSE IN PINES</u> | | | | d. STREET ADDRESS
<u>128 SANFORD AVE.</u> | | a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>ETHEL B. STEINACKER</u> | | | | 4. DATE OF DEATH
Month <u>FEB</u> Day <u>24</u> Year <u>1962</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>5/7/86</u> | 9. AGE (In years last birthday)
<u>75</u> Yrs. | IF UNDER 1 YEAR
Months <u></u> Days <u></u> | IF UNDER 24 HRS.
Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Homemaker</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Charles Smallwood</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Kate Essey</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
<u>Francis J. Heird</u>
Address <u></u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
DUE TO <u>422</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u>
DUE TO <u>Cardiovascular disease</u>
(c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 mo</u>
<u>5 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u>19</u> p.m. <u></u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1961</u> to <u>Feb 24 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 27 1962</u> and that death occurred at <u>6:45</u> A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>B B Brubaker</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>2/28/62</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>B B Brubaker</u> | | | | 22d. ADDRESS
<u>5609 main st</u>
<u>Elbridge 22 Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>2/26/62</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>LOUDON PARK</u> | | 23d. LOCATION (City, town or county) (State)
<u>BALTO. MD.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Brubaker - Don</u> | | | | ADDRESS
<u>(28)</u> | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 27 '62</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles S. Hume</u> | | | |

01681

01672

(M)

Kate E. Cope
Museum of Natural History

Albion, New York

2/1/06

STEINWATER

ETHEL A. STEINWATER

25 Station Ave.

1000 N. 1st St.

Albion, N.Y.

1895

1895

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 1c Film G307 2/21/62 iwk

| | | | |
|--|---------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN 1b 1 yr. 6 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY H. H. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 205 Hanover St.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Melville
First Middle Last
C Stockwell | | 4. DATE OF DEATH
Month Day Year
2 12 1962 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-1-09 |
| 9. AGE (In years last birthday) 52 yrs. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Progr. food merchant | | 10b. KIND OF BUSINESS OR INDUSTRY Ba. | |
| 11. BIRTH PLACE (County & State, or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Herbert G. Stockwell | | 14. MOTHER'S MAIDEN NAME Meta Melville | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. 20-20-4 | |
| 17. INFORMANT Julia T. Stockwell | | Address (2) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Cardiac Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Myocardial Infarctum.
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associate & Alzheimer's disease & Psychosis | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug. 12, 1960 to Feb. 12, 1962 that (I) (we) last saw the deceased alive on Feb. 12, 1962 , and that death occurred at 6 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Jose R. Arizaga
M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22b. DATE SIGNED 2/12/62 | |
| 22c. PHYSICIAN'S NAME (Type) Jose R. Arizaga, M.D. | | 22d. ADDRESS Spring Grove State Hospital (28) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2-14-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY St Annes Cem | | 23d. LOCATION (City, town or county) (State) Annapolis Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons | | ADDRESS Annapolis, Md. | |
| 25a. REC'D BY REGISTRAR FEB 16 '62 | | 25b. REGISTRAR'S SIGNATURE Charles L. Hume | |

01085

01085

(M)

For K. R. R. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
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01681

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01663

| | | | |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>EIKRIDGE</u> | | c. LENGTH OF STAY IN 1b
<u>Years.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Rt # 4 Box 257A</u> | | d. STREET ADDRESS
<u>Rt # 4 Box 257A</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Nicholas</u> First Middle Last | | 4. DATE OF DEATH Month <u>Feb</u> Day <u>5</u> Year <u>1962</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 9, 1896</u> |
| 9. AGE (In years lost birthday)
<u>65</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Hickster</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Self-Employed</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>BALTO. MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | |
| 13. FATHER'S NAME
<u>Henry</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARY W.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> (If yes, give war or dates of service)
<u>WWI</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | |
| 17. INFORMANT
<u>Nicholas Stolzenbach Jr. Rt # 4 Box 257A</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the lung, left</u>
163X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized carcinoma</u>
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Norfolk</u> <u>1961</u> , to <u>Feb - 5</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>Feb - 5</u> <u>1962</u> , and that death occurred at <u>4:29 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>E. Roderick Shipley</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED
<u>2-6-62</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>E. Roderick Shipley</u> | | 22d. ADDRESS
<u>529 Camp Meade Road Fort Detrick</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Feb 8, 1962</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>West Laurel Cem</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Frederick Co Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Geo H Schwab</u> | | ADDRESS
<u>2101 Frederick Ave</u> | |
| 25a. REC'D BY REGISTRAR
<u>Feb 13 '62</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

1081

CERTIFICATE OF DEATH

1081



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01664

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 506 Holden Road | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson
d. STREET ADDRESS 506 Holden Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) GAVIN JOSEPH STRINGER | | 4. DATE OF DEATH
Month February Day 21 Year 1962 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 9, 1873 |
| 9. AGE (In years last birthday) 89 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Estate Manager - Retired Private Estate | 11. BIRTHPLACE (County & State, or foreign country) Ireland |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown | |
| 14. MOTHER'S MAIDEN NAME Unknown | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. - - | | 17. INFORMANT Harry Stringer, 506 Holden Rd., Towson, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
420.1 DUE TO (b) Coronary Artery Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour e.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from June 1962 to 2/21 1962, that (I) (we) last saw the deceased alive on 2/21 1962 and that death occurred at 7P M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE George T. Gilmore M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Dr George T. Gilmore | | 22d. ADDRESS Hanham Bldg, York Rd, Lutherville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Feb. 26, 1962 | 23c. NAME OF CEMETERY OR CREMATORY Holy Rood Cemetery | 23d. LOCATION (City, town or county) (State) Westbury, New York |
| 24. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons | | 25. REC'D BY REGISTRAR FEB 26 '62 | |
| ADDRESS Towson, Maryland | | 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

01651

21252



Station

Station

Town

Town

500 Holden Road

500 Holden Road

QW 111

100001

STANDARD

February 21, 1962

White

x

February 9, 1972

50

State Highway - Highway Private Property

Private Property

Unknown

Unknown

500

500

- - -

State Highway, 500 Holden Rd., Town, N.Y.

Handwritten notes:
State Highway 500 Holden Rd.
Town, N.Y.

State Highway 500 Holden Rd., Town, N.Y.

• also, 1972

01683

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G307 2/16/62 iwk

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

BALTO. CO.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CATONSVILLE

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

DOELLA MD

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

DOELLA, MD.

d. STREET ADDRESS

12514 OLD FREDERICK RD

e. IS RESIDENCE ON A FARM?
YES ☒ NO ☐3. NAME OF DECEASED
(Type or print)

JAMES CARSON TAYLOR

4. DATE OF DEATH

FEB 8

Day Year 19 62

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

NOV. 1 1892

9. AGE (in years last birthday)

69 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY

RET.

11. BIRTHPLACE (State or foreign country)

VA.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLES H. TAYLOR

14. MOTHER'S MAIDEN NAME

ALLEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO. (If yes, give war or dates of service)

212 05 3853

17. INFORMANT

Mabel Cox - Sister

Address Vienna Va

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4-20-1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a. m. p. m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐. Inspection ☒. Inquiry ☒ and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE

Geo. S. M. Kieffer

M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type)

GEO. S. M. KIEFFER MD

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

Feb 8 62

22a. BURIAL, CREMATION, REMOVAL (Specify)

CREMATION 2/12/62

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

LOUDON PARK

22d. LOCATION (City, town, or county)

BALTO. MD.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Macraft & Son (28)

ADDRESS

24a. REC'D BY REGISTRAR

DATE FEB 13 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



[Faint, mostly illegible text and markings on the form, including what appears to be a signature in the center.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. Pages may be retained by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01684

01666

| | | | |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>
c. LENGTH OF STAY IN 1b <u>5 YRS.</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>29 Walker aer</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Balto.</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>
d. STREET ADDRESS <u>29 Walker aer</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>ARDA</u> <u>THOMAS</u> | | 4. DATE OF DEATH <u>FEBRUARY 3</u> 19 <u>62</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-18-1889</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor of Bldg - Canton Co</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Canoe Co. Md</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Thomas</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine Stover</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>214-01-8795</u> | |
| 17. INFORMANT <u>Mr Mary Louise Thomas (Wife)</u> | | Address <u>29 Walker aer</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u>
332X DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>
(a), stating the underlying cause last. DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER, 1961</u> , to <u>FEB. 3, 1962</u> , that (I) (✓) last saw the deceased alive on <u>JAN 30</u> 19 <u>62</u> , and that death occurred at <u>4P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Herbert L. Blumenfeld MD</u> M.D. | | 22b. DATE SIGNED <u>FEB. 3, 1962</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>HERBERT L. BLUMENFELD</u> | | 22d. ADDRESS <u>2506 RELLIM RD, BALTIMORE 9, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>2-6-62</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Grain Ridge</u> | | 23d. LOCATION (City, town or county) (State) <u>Pikesville & Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville Md.</u> | | 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | |
| DATE <u>FEB 5 '62</u> | | | |

(M)

01082

STATEMENT OF DEATH

01082

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text appears to be a narrative or statement, possibly related to a death, given the header. It is written in cursive and spans most of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01685 CERTIFICATE OF DEATH 01667

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
e. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Parkville</i> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Parkville</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>8500 Harford Road</i> | | d. STREET ADDRESS
<i>8500 Harford Road</i> | |
| 3. NAME OF DECEASED (Type or print)
First <i>Mrs.</i> Middle <i>Mary</i> Last <i>Turek</i> | | 4. DATE OF DEATH
Month <i>February</i> Day <i>17</i> Year <i>1962</i> | |
| 5. SEX
<i>female</i> | 6. COLOR OR RACE
<i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Dec. 23, 1893</i> |
| 9. AGE (In years last birthday)
<i>68</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | 11. BIRTHPLACE (County & State, or foreign country)
<i>Baltimore, Maryland</i> |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>Michael Wasik</i> | |
| 14. MOTHER'S MAIDEN NAME
<i>Mary Ann Czyzkoska</i> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Mr. Andrew Turek, Jr.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)
<i>1962</i> DUE TO, <i>Carcinoma of brain with Glioblastoma Multiforme</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
<i>Enlarging meninges only to Glioblastoma Multiforme</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 1/2 yrs</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from <i>5 August 1962</i> to <i>17 Feb 1962</i> , that (I) (we) last saw the deceased alive on <i>17 Feb 1962</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Howard Goodman</i> | | 22b. DATE SIGNED
<i>Feb 20 1962</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>Dr. Howard Goodman</i> | | 22d. ADDRESS
<i>6604 Harford Rd</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE THEREOF
<i>2/20/62</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Sacred Heart Cemetery</i> | | 23d. LOCATION (City, town or county) (State)
<i>Baltimore, Maryland</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Leonard J. Ruck</i> | | 25a. REC'D BY REGISTRAR
<i>FEB 20 1962</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Christina S. Hines</i> | | | |

01687

1301

M

Commence of war with Japan, 1941

End of war with Japan, 1945

1941

1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01686

CERTIFICATE OF DEATH

Reg. Dist. No. 01668

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Monkton</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X Rural Monkton</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS
<u>Troyer Road</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <u>Alice</u> Middle <u>Mae</u> Last <u>Urich</u> | | | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>10</u> Year <u>19 62</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct. 16, 1948</u> | | 9. AGE (In years last birthday)
<u>13</u> yrs. | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Sparks school</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore City Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Joseph J. Urich</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Edith Dunmoyer</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>---</u> | | INFORMANT
<u>Joseph J. Urich</u> Address <u>Monkton, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
480X DUE TO (b) <u>Virus infection (flu)</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH
<u>6 hr</u>
<u>1 wk</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. _____
19 _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb 3</u> , 19 <u>62</u> , to <u>Feb 10</u> , 19 <u>62</u> that I last saw the deceased alive on <u>Feb 10</u> , 19 <u>62</u> , and that death occurred at <u>9 A</u> : M, from the causes and on the date stated above.
ACTUAL SIGNATURE <u>C. Herbert Mueller</u> M.D. ADDRESS (Street, city or town, state) <u>Packton Md.</u> DATE SIGNED <u>2-11-62</u>
PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER, Jr.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>2/12/1962</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Wesley Chapel</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Monkton, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles E. Rutz</u> Address <u>Jarrettsville, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>FEB 13 '62</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hume</u> | |

01828

CERTIFICATE OF DEATH

01828



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01687 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01669

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore County</i>
<i>Eastern Ave Chase Md</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <i>md</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Box 20 Route 14 Bel Air</i> | c. LENGTH OF STAY IN 1b
<i>life</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>X Chase md</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Eastern Ave. Chase Md.</i> | | d. STREET ADDRESS
<i>Box 20 Route 14</i> | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<i>James Henry Venev</i> | 4. DATE OF DEATH
Month Day Year
<i>Feb. 16 1962</i> | | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>Cel</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>JUN 5 1876</i> |
| 9. AGE (In years last birthday)
<i>86 yrs.</i> | | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired</i> | 10b. KIND OF BUSINESS OR INDUSTRY
<i>md.</i> | 11. BIRTHPLACE (State or foreign country)
<i>md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME
<i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME
<i>Unknown</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. 17. INFORMANT
Address
<i>Ida Mae Taylor Box 20 Route 14 Bel Air</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>A-S-C-V-DISEASE</i>
4 <i>120</i> } DUE TO <i>Senility</i>
Conditions, if any, which gave rise to immediate cause (b) }
(c), stating the underlying cause last. } DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
<i>None</i> | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m.
<i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<i>M.B. Davis</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<i>M.B. DAVIS MD</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county)
<i>7/17/62</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 22b. DATE THEREOF
<i>Feb. 19/62</i> | 22c. NAME OF CEMETERY OR CREMATORY
<i>Mt. Calvary Cem</i> | 22d. LOCATION (City, town, or county) (State)
<i>A.A. County Md</i> |
| 23. FUNERAL DIRECTOR
<i>Milton E. Elickson</i> | | 24a. REC'D BY REGISTRAR
DATE <i>FEB 19 '62</i> | |
| ADDRESS
<i>112977 Carolina St</i> | | 24b. REGISTRAR'S SIGNATURE
<i>Robert S. ...</i> | |

MEDICAL CERTIFICATION

01000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15 (4)
1SM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01670

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
31 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
8 Maple Avenue | | d. STREET ADDRESS
8 Maple Avenue | |
| 3. NAME OF DECEASED (Type or print)
First Alfred Middle Vernon Last Wall | | 4. DATE OF DEATH
Month Feb. Day 2 Year 1962 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 2, 1878 |
| 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Attorney | | 10b. KIND OF BUSINESS OR INDUSTRY
Practice of law | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Alexander Wall | | 14. MOTHER'S MAIDEN NAME
Ida Clements | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
Yes W.W.I. | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. Marie V. Wall | | Address
8 Maple Ave. Catonsville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.1 Anterograde cardiovascular disease
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
DUE TO _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs + | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (the hospital) attended the deceased from Nov 1962 to Feb 2 1962 that (I) (we) last saw the deceased alive on Feb 2 1962 and that death occurred at 3:45 P. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
John A. Nesbitt Jr. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
John A. Nesbitt Jr. | | 22d. ADDRESS
4 S. Rolling Rd. Catonsville - 28, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | 23b. DATE THEREOF
Feb. 5, 1962 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Crematory | 23d. LOCATION (City, town, or county) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Easton Funeral Home | | 25a. REC'D BY REGISTRAR
DATE FEB 5 '62 | |
| ADDRESS
Catonsville, Md. | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | |

Catonville, Md.

Creation Feb. 2, 1962 London Park Cemetery Baltimore, Md.

John A. Nesbitt Jr. A. S. Melling Md. Catonville - 22, Md.

Yes World War Two Home Mrs. Marie V. Wall 8 Maple Ave. Catonville, Md.

Alexander Wall Mrs Clements

Attorney Practice of Law Virginia U. S. A.

Male White

Sept. 2, 1878

83

Alfred

Vermon

Wall

Feb. 2,

82

8 Maple Avenue

8 Maple Avenue

31 yrs.

Catonville

Catonville

Baltimore

Baltimore

Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01689

01671

| | | | | | | |
|--|----------------------------------|---|---|---|---|---|
| 1. PLACE OF DEATH
e. COUNTY
Baltimore
f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard
g. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
STATE
Maryland
b. COUNTY
-
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 26
d. STREET ADDRESS
3714 Fairhaven Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First
LEONARD
Middle

Last
WALLIS | | 4. DATE OF DEATH
Month
February
Day
14
Year
19 62 | | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
January 29, 1893 | 9. AGE (In years last birthday)
69 yrs. | IF UNDER 1 YEAR
Months
0
Days
0 | IF UNDER 24 HRS.
Hours
0
Min.
0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Proprietor | | 10b. KIND OF BUSINESS OR INDUSTRY
Tavern | | 11. BIRTHPLACE (County & State, or foreign country)
Poland - | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. |
| 13. FATHER'S NAME
Norbert Welez | | 14. MOTHER'S MAIDEN NAME
Anna Kaiszo | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
219-32-1763 | | 17. INFORMANT
Address
Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
420.0 ARTERIOSCLEROTIC HEART DISEASE WITH ATRIAL FIBRILLATION AND RIGHT BUNDLE BRANCH BLOCK
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
(b)
CHRONIC BRAIN SYNDROME DUE TO CEREBRAL ARTERIOSCLEROSIS.
(c)
POSTERIOR URETHRAL STRICTURE; CYSTITIS; CHRONIC PYELONEPHRITIS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Brain Syndrome due to cerebral Arteriosclerosis. Posterior urethral Stricture; cystitis; chronic pyelonephritis.
INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 20a. TIME OF INJURY
Hour e.m.
p.m.
19 | | 20b. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (this hospital) attended the deceased from January 5, 1962, to February 14, 1962 , that (we) last saw the deceased alive on 2/14/1962 , and that death occurred at A.M. , from the causes and on the date stated above. | | | | | | |
| 22a. SIGNATURE
Irving Freeman | | 22b. ADDRESS
IRVING FREEMAN, M.D. Chief, Medical Service VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION | | 22c. PHYSICIAN'S NAME (Type)
IRVING FREEMAN, M.D. Chief, Medical Service VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION | | 22d. ADDRESS
Baltimore 18, MD., FORT HOWARD DIVISION |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/19/62 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Fialkowski Funeral Home | | 24b. ADDRESS
2007 Eastern Ave | | 25a. REC'D BY REGISTRAR
FEB 16 '62 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kucera |

07630



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01690 CERTIFICATE OF DEATH 01672

| | | | | |
|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>-</u> | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville (7)</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BAL To Md 3x01-4</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Augsburg Lutheran Home</u> | | d. STREET ADDRESS <u>2230 GARRISON BLVD</u> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>WARfield</u> Last <u>d</u> | | 4. DATE OF DEATH Month <u>Feb</u> Day <u>2</u> Year <u>1962</u> | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 14, 1877</u> | |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> | IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>BAL To. County</u> | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>David Kalb</u> | | 14. MOTHER'S MAIDEN NAME <u>Long</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | |
| 17. INFORMANT <u>-</u> | | Address <u>-</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>(1) - Broncho-Pneumonia</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>(2) - Arterio-Sclerotic Heart Disease</u>
DUE TO
(c) <u>(3) - Cerebral Thrombosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>5 yrs.</u>
<u>2 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Generalized Arterio Sclerosis</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u>
p.m. <u>-</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 1960</u> to <u>Feb 2, 1962</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>Feb 1st 1962</u> , and that death occurred at <u>3A.M.</u> from the causes and on the date stated above. | | | | |
| 22a. SIGNATURE <u>Earl L. Chambers</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u> | | 22d. ADDRESS <u>4008 Liberty Hts. Balto. Md</u> | | |
| 22b. DATE SIGNED <u>2/2/62</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>2-5-1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Baltimore Co - Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. MacNabb</u> | | ADDRESS <u>Catonsville Md</u> | | |
| 25a. REC'D BY REGISTRAR <u>Feb 5 '62</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | |

(M)

Handwritten notes, possibly a list or index, including names like "Balt. County" and "Harrisville".

Extensive handwritten notes, possibly a list or index, covering the bottom half of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
e. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>md</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>213 Clarendon Ave.</u> | | d. STREET ADDRESS <u>213 Clarendon Ave</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>ALMA MAY WARREN</u> | | 4. DATE OF DEATH
Month <u>2</u> Day <u>6</u> Year <u>1962</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 20-1876</u> |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Norway</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Groot</u> | | 14. MOTHER'S MAIDEN NAME <u>Christin Larson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mr Thomas Warren</u> | | Address <u>213 Clarendon Ave.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
331X DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u> </u>
DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour <u> </u> e.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above, | | | |
| 22a. SIGNATURE <u>S. Kaplan M.D.</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>2-10-62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u> | 23d. LOCATION (City, town or county) (State) <u>Baltimore</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u> | | 25a. REC'D BY REGISTRAR <u>FEB 8 '62</u> | |
| ADDRESS <u>Pikesville, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

CERTIFICATE OF DEATH

1910

M

[Faint, mostly illegible handwritten text, likely a death certificate form with fields for name, date, and cause of death.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01692

CERTIFICATE OF DEATH

01674

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3113 Northbrook Road | | d. STREET ADDRESS 3113 Northbrook Road | |
| 3. NAME OF DECEASED (Type or print) LEON WEISS First Middle Last | | 4. DATE OF DEATH February 11, 1962 Month Day Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH JUNE 27, 1907 |
| 9. AGE (In years lost birthday) 54 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor | | 10b. KIND OF BUSINESS OR INDUSTRY Delocatessen | |
| 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Abraham Isaac Weiss | | 14. MOTHER'S MAIDEN NAME Bessie ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Fannie Weiss-3113 Northbrook Rd | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
4-20-1 IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 15 minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 15, 1962 to Feb 11, 1962 , that I last saw the deceased alive on Feb 11, 1962 , and that death occurred at 5A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Seymour H. Rubin M.D. | | PHYSICIAN'S NAME (Type) Seymour H. Rubin 3312 Olympia Avenue | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb 11/62 | |
| 22c. NAME OF CEMETERY OR CREMATORY Jewish National Forband, Rosedale, Md. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Sol, Levinson & Bros Inc ADDRESS 6010 Reist Road | | 24a. REC'D BY REGISTRAR FEB 14 '62 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kross | | | |

(M)

June 27, 1967

Forward

Basile

Mr. Basile is being held in custody

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

01693 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01675

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN 1b 18 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin
d. STREET ADDRESS Rural Route 3
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) GEORGE E. WHITE | | | | 4. DATE OF DEATH February 14 1962 | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH December 25, 1895 | | | | | |
| 9. AGE (In years last birthday) 66 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer | | 11. BIRTHPLACE (State or foreign country) Berlin, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | |
| 13. FATHER'S NAME HENRY WHITE | | | | 14. MOTHER'S MAIDEN NAME MARY HENRY | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I | | | | 16. SOCIAL SECURITY NO. 216-09-8891 | | | | | | | |
| 17. INFORMATION Clinical Records, VAH, Baltimore 18, Maryland Fort Howard, Division | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, LEFT LUNG
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
3rd Degree Burn of left leg and knee | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour NONE e.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE M B Davis | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| EXAMINER'S NAME (Type) MELVIN B. DAVIS, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 2-19-62 | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY New Bethel Cemetery | | | | 22d. LOCATION (City, town, or country) (State) Berlin, Maryland | | | | | | | |
| 23. FUNERAL DIRECTOR Thornton B. Jolley, Jersey Road, Salisbury, Md. | | | | 24a. REC'D BY REGISTRAR FEB 21 '62 | | | | | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. House | | | | | | | |

01873

01893

(M)

REPORT OF THE
COMMISSIONER OF THE
BUREAU OF THE
LAND OFFICE
OF THE
STATE OF
NEW YORK
IN
RESPONSE TO A
RESOLUTION OF THE
SENATE
PASSED
JANUARY 10, 1893
RELATIVE TO
THE
LANDS
OWNED BY
THE
STATE OF
NEW YORK
IN
THE
COUNTY OF
SARATOGA
AND
ADJACENT
COUNTIES
AND
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COUNTIES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01694

CERTIFICATE OF DEATH

01678

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
e. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u> | | | | | |
| c. LENGTH OF STAY IN 1b <u>4 wks.</u> | | | | d. STREET ADDRESS <u>1005 Boyce Ave.</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1005 Boyce Ave.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Grace</u> Middle <u>Elizabeth</u> Last <u>Wick</u> | | | | 4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1962</u> | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-6-1871</u> | | | |
| 9. AGE (In years last birthday) <u>90</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |
| 13. FATHER'S NAME <u>Frank Gerahty</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Julia Kelley</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>no</u> | | | | | |
| 17. INFORMANT <u>Mrs. Grace W. vanZelm</u> | | | | Address <u>Above</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) <u>Cerebrovascular Thrombosis</u>
<u>332</u> DUE TO <u>arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 mos. 10 yrs</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>See</u> | | 20f. (City or town) <u>Balto</u> (County) <u>62</u> (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 26</u> 19 <u>62</u> to <u>Feb 26</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Feb 26</u> 19 <u>62</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>William F. Fritz</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>William F. Fritz</u> | | | | 22d. ADDRESS <u>2 W. University Parkway, Balto.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>3-2-62</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Beechwoods</u> | | 23d. LOCATION (City, town or county) <u>New Rochelle</u> (State) <u>N.Y.</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd. Balto. 12, Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>MAR 1 '62</u> | | 25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u> | | | |

100000

100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01695

01677

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
<i>Balto. Co.</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE
<i>Maryland</i>
b. COUNTY
<i>Baltimore</i> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Balto County</i> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Middle River #20</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>Long Hall Convent Home</i> | | d. STREET ADDRESS
<i>209 A Long Beach</i> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<i>Bertha Williams</i> | | 4. DATE OF DEATH
Month Day Year
<i>2 / 16 1962</i> | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>June 19, 1901</i> |
| 9. AGE (In years last birthday)
<i>60 yrs.</i> | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Home</i> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY
<i>USA</i> | |
| 13. FATHER'S NAME
<i>William Brooks</i> | | 14. MOTHER'S MAIDEN NAME
<i>Mary Lightner</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<i>No --</i> | | 16. SOCIAL SECURITY NO.
<i>213 28 4173</i> | |
| 17. INFORMANT
<i>Sidney J. Williams</i> | | Address
<i>Same</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebro-Vascular accident</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) <i>arteriosclerotic Cardio-Vascular disease</i>
(a), stating the underlying cause last. (c) <i>Diabetes Mellitus</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 years</i>
<i>5 years</i>
<i>10 years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
<i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1 1960</i> to <i>Feb 16 1962</i> , that (I) (we) last saw the deceased alive on <i>Feb 15 1962</i> , and that death occurred at <i>3:15 P.M.</i> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>G. Baumgardner</i> | | 22b. DATE SIGNED
<i>2/16/62</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>G. Baumgardner, M.D.</i> | | 22d. ADDRESS
<i>Balto 6 Md</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE THEREOF
<i>2/19/62</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Gardens of Faith Cemetery</i> | | 23d. LOCATION (City, town or county) (State)
<i>Baltimore, Md.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>James E. Brudzinski</i> | | 25a. REC'D BY REGISTRAR
<i>DATE FEB 19 '62</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Hanna</i> | | | |

01657

01657

(M)

Housewife
Name
Living
USA
William Brown
213 28 Ave
St. Louis
Mo

Handwritten notes in cursive script, mostly illegible.

James A. Smith, 1907
Department of State
Washington, D.C.
1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01696 CERTIFICATE OF DEATH 01678

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
e. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | d. STREET ADDRESS
516 Sanford Place | |
| 3. NAME OF DECEASED (Type or print)
First Virgil Middle H. Last Williams, Sr. | | 4. DATE OF DEATH
Month February Day 11 Year 1962 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
September 26, 1896 |
| 9. AGE (In years last birthday)
65 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
File Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
U. S. Government | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Samuel W. Williams | | 14. MOTHER'S MAIDEN NAME
Lillian G. Matthews | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes | | 16. SOCIAL SECURITY NO.
212-18-4297 | |
| 17. INFORMANT
Clinical Records, VA Hospital, 3900 Loch Raven Blve. Balto. Md. Ft. Howard Div. | | 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) METASTATIC CARCINOMA TO ABDOMEN
DUE TO 154X
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
(b) CARCINOMA OF RECTUM
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).
BENIGN PROSTATIC HYPERTROPHY. ARTERIOSCLEROTIC HEART DISEASE. | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN
3 YEARS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 3 , 19 62 , to Feb 11 , 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 11 , 19 62 , and that death occurred at 2:10AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Donald W. Stewart M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 2/11/62 | |
| 22c. PHYSICIAN'S NAME (Type)
DONALD W. STEWART, M. D. | | 22d. ADDRESS
VAH, BALTO. MD. FT HOWARD DIV. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-14-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore, National | | 23d. LOCATION (City, town or county) (State)
Baltimore 28, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles Lewis Funeral Dir. 1639 N. Broadway, Balto. Md. | | 25a. REC'D BY REGISTRAR
FEB 15 '62 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | | | |

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(M)

210 2nd St. S.W.

Box 8

Lowell, Mass.

International Brotherhood of Teamsters

Virginia

September 11, 1960

Dear Sir:

State Clerk, U.S. Government, Baltimore, Maryland

Samuel W. Williams

Little - Baltimore

General, 2nd St. S.W.

210-15-237 (Box 8) Lowell, Mass. and Div.

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Wm. H. H. H. H. H.

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Charles Lewis Federal Bldg. 1039 N. Broadway, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01697

01679

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>
c. LENGTH OF STAY in 1b <u>6 yrs.</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE <u>Md.</u>
b. COUNTY <u>Balto</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>
d. STREET ADDRESS <u>855 B. Jerome Ave</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>MARY</u> Middle <u>F.</u> Last <u>WILSON</u> | | 4. DATE OF DEATH
Month <u>Feb</u> Day <u>25</u> Year <u>1962</u> | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>June 29 - 1879</u> | |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charleton</u> | | 14. MOTHER'S MAIDEN NAME <u>Craft</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mrs. James B. Elmore</u> | | Address <u>(Same)</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
DUE TO <u>331X</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>Generalize Arteriosclerosis</u>
(c) <u>Influenza</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>481X</u> | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 23</u> , 19 <u>60</u> , to <u>Feb.</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Febr. 23</u> , 19 <u>62</u> , and that death occurred at <u>9 a.</u> M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Theodore E. Evans</u>
M.D. | | 22b. DATE SIGNED
<u>2/26/62</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Theodore E. Evans, M.D.</u> | | 22d. ADDRESS
<u>9660 Belair Rd.</u> | |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify)
<u>Removal</u> | | 23b. DATE THEREOF
<u>2-25-62</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Humphries Cem.</u> | | 23d. LOCATION (City, town or county) (State)
<u>Rich patch - Va.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>John S. Connelly</u> | | 25a. REC'D BY REGISTRAR
<u>MAR 1 1962</u>
DATE | |
| 25b. REGISTRAR'S SIGNATURE
<u>James B. Elmore</u> | | | |



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John W. Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01698

Item 9 Film G307 2/26/62 iwk

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|--|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) AERO ACRES
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 23 COMPASS ROAD BALTO 20, MD. | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY BALTIMORE
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X AERO ACRES
d. STREET ADDRESS 123 COMPASS ROAD BALTO 20, MD
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First ROBERT Middle D Last WILSON | | | 4. DATE OF DEATH
Month FEB Day 21 Year 1962 | | |
| 5. SEX MALE | | | 6. COLOR OR RACE WHITE | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH MARCH 17, 1907 54 55 yrs. | | |
| 9. AGE (In years last birthday) 54 yrs. | | | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXPIDITER | | | 10b. KIND OF BUSINESS OR INDUSTRY MARTIN CO. | | |
| 11. BIRTHPLACE (County & State, or foreign country) Clarksburg W Va. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME ROBERT WILSON | | | 14. MOTHER'S MAIDEN NAME SARAH CASTEL | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. 232-01-7231 | | |
| 17. INFORMANT MRS. ROBERT WILSON Address 23 COMPASS RD #20. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4 20.1 DUE TO Hypertensive cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Atherosclerosis
DUE TO Atherosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paroxysmal tachycardia, Pneumonitis | | | INTERVAL BETWEEN ONSET AND DEATH Immed 20 yrs | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m. | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (1) (this hospital) attended the deceased from O.C.T. 1957 to Feb 21 1962 that (1) (not) last saw the deceased alive on Feb 21 1962 and that death occurred at 7 AM from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE John B Little MD M.D. | | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type) John B Little MD | | | 22d. ADDRESS 1515 Martin Blvd Balto 20md | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE THEREOF 2/24/62 | | |
| 23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM PARK | | | 23d. LOCATION (City, town or county) (State) BALTO. MD. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home | | | 25a. REC'D BY REGISTRAR 7401 Belair Rd. #6 DATE FEB 23 '62 | | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kiana | | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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|--|-----------------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print) WISKEMAN, Marie E | | 2. DATE OF DEATH
Feb. 24, 1962 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION Baltimore County Forest Haven Nursing Home 315 INGLETSIDE AVE CATONSVILLE, MD
<small>(If not in hospital or institution, give street address or location)</small> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY - | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| | | D. STREET ADDRESS (If rural, give location)
2126 W. Saratoga St. | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Widowed | 8. DATE OF BIRTH
Nov. 11, 1871 |
| 9. AGE (In years last birthday)
90 | | If Under 1 Yr. If Under 24 Hrs.
Months: Days: Hours: Min. | |
| 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dressmaker | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
John C Wagner | | 14. MOTHER'S MAIDEN NAME
Beck | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Philip H Wiskeman | | ADDRESS
3049 Parktowne Rd. 14 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<small>(This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small>

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
422-1 GASTRIC HEMORRHOGE | |
| | | (A) DUE TO | |
| | | (B) DUE TO ARTERIO SCLEROTIC DISEASE | |
| | | (C) DUE TO VESICULAR DISEASE | |
| 19. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II | | | |
| I certify that (I) (this hospital) attended the deceased from 2/23 1962 that (I) (we) last saw the deceased alive on 2/23 1962 and that in (my) (our) opinion death occurred at 1/1/ m., from the causes and on the date stated above. | | | |
| 23A. SIGNATURE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.
Philip H Wiskeman | | 23B. ADDRESS
6500 EDMONSON AVE #28 | |
| 23C. DATE SIGNED
2/24/62 | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 24c. DATE
Feb. 26, 1962 | 24c. NAME OF CEMETERY OR CREMATORY
Baltimore | 24d. LOCATION (City, town, or county) (State)
Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 27 '62 | | 25c. NAME OF REGISTRAR
William A. 7 months | |
| 25c. FUNERAL DIRECTOR
Wm. Cook Inc. | | ADDRESS
1217 St. Paul St. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
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| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 01700 | | | | | | | | | | | |
| 01683 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 12 Hillview Rd | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville
d. STREET ADDRESS 12 Hillview Rd | | | | | |
| 3. NAME OF DECEASED (Type or print) Mildred Workman | | | | | | 4. DATE OF DEATH February 1, 1962 | | | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 15, 1896 | | 9. AGE (In years last birthday) 65 yrs. | | 10. IF UNDER 1 YEAR Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Edward Woodall | | 14. MOTHER'S MAIDEN NAME Nettie Marshall | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. None. | | 17. INFORMANT Mr. Charles J. Workman, 327 Lambeth Rd. #28. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO with acute coronary thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1
DUE TO (b) with acute coronary thrombosis
DUE TO (c) with acute coronary thrombosis | | INTERVAL ONSET AND DURATION | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 20g. (City or town) (County) (State) | | 20h. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Rudiger Breitenecker
EXAMINER'S NAME (Type) Assistant Medical Examiner | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED February 2, 1962 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2/5/62 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemty. | | 22d. LOCATION (City, town, or country) (State) Balto. Md. | | 23. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave. | | 24a. REC'D BY REGISTRAR FEB 5 '62 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | | | | | | | | | | |



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Aug. 15, 1898

Our House

House 112

Walter Woodhall

Walter Woodhall

Wm.

Wm.

Wm. Woodhall, 207 Lincoln St., Wm.



Walter Woodhall

Walter Woodhall

Walter Woodhall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01701

01684

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1527 N. Spring Street</u> 3V01-4
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
d. STREET ADDRESS <u>Baltimore</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>
c. LENGTH OF STAY IN 1b <u>1 yr.</u> | | 3. NAME OF DECEASED (Type or print) <u>Ellen Jackson Stewart</u> First Middle Last
4. DATE OF DEATH <u>Feb 1</u> Month Day Year <u>1962</u> | |
| 5. SEX <u>Female</u>
6. COLOR OR RACE <u>Negro</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 13, 1878</u>
9. AGE (In years last birthday) <u>83</u> yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Md.</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>
12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME <u>David Stewart</u>
14. MOTHER'S MAIDEN NAME <u>Adeline Stewart</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>
16. SOCIAL SECURITY NO. <u>Phoebe Nelson</u>
17. INFORMANT Address <u>1806 Mount Street</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u>
204.4 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Leukemia</u> DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>
<u>3 yrs.</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year <u>19</u>
Hour a.m. p.m.
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>January 4, 1962</u> , to <u>February 1, 1962</u> that (I) (we) last saw the deceased alive on <u>February 1, 1962</u> , and that death occurred at <u>11A</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Martin E. Strobel</u> M.D.
22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u> | | 22b. DATE SIGNED <u>2-3-62</u>
22d. ADDRESS <u>48 Main St. Reisterstown, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>
23b. DATE THEREOF <u>2/5/62</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>
23d. LOCATION (City, town or county) (State) <u>Ann Arundel Cty Md.</u> | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm C. March</u> ADDRESS <u>928 E. North Ave.</u>
25a. REC'D BY REGISTRAR DATE <u>FEB 6 '62</u>
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

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01410

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01702 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01685

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Essex (21) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Essex (21) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
407½ Eastern Blvd. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Wilburn Monroe Yother | | | | 4. DATE OF DEATH
Month February Day 13 Year 1962 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Aug. 29, 1917 | |
| 9. AGE (In years, months, days)
44 yrs. | | IF UNDER 1 YEAR
Months 4 Days 4 | | IF UNDER 24 HRS.
Hours 4 Min. 4 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chef | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Restaurant | | 11. BIRTHPLACE (State or foreign country)
South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
Ellwood G. Yother | | | | 14. MOTHER'S MAIDEN NAME
Mamie Pinion | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes | | | | 16. SOCIAL SECURITY NO.
248 28 3864 | | 17. INFORMANT
Adeline Yother Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO Hypertensive Cardi-Vascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (b) 4201
DUE TO (c) 4201 | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
None | | | |
| 20c. TIME OF INJURY
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
M. B. Davis | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
M. B. Davis, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county)
Spartanburg, S.C. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 22b. DATE THEREOF
2/14/62 | | 22c. NAME OF CEMETERY OR CREMATORY
J.F.Floyd Mortuary, Inc. | | 22d. LOCATION (City, town, or country) (State)
Spartanburg, S.C. | |
| 23. FUNERAL DIRECTOR
James E. Bruzdinski | | | | 24a. REC'D BY REGISTRAR
FEB 15 '62 | | 24b. REGISTRAR'S SIGNATURE
S. Kraus | |

MEDICAL CERTIFICATION

(M)

01008

01008

MEDICAL EXAMINER'S REPORT

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|--|--|--|---|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 01703 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01686 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sparrows Point
c. LENGTH OF STAY IN lb
Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Bethlehem Steel Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
121 S. Chester Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
ADAM
First Middle Last
ZAWORSKI | | | | | | 4. DATE OF DEATH
Month Day Year
February 22, 1962 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2/17/1905 | | 9. AGE (In years last birthday)
57 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Stevedore | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Stephen Zaworski | | | | | | 14. MOTHER'S MAIDEN NAME
Kowalski | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT
Victoria Zaworski 121 S Chester St
Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Thrombotic Coronary Artery Occlusion
DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Coronary Artery Sclerosis; with myocardial infarcts
DUE TO
(c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Carbon-monoxide poisoning
Arteriosclerosis generalized and chronic pericarditis | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Collapsed while loading steel in hold of ship | | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. / Month, Day, Year
4:40 PM / Feb. 22, 1962 | | | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
shipyard Sp. Point Balto. Md. | | | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Howard G. Shaub
EXAMINER'S NAME (Type)
HOWARD G. SHAUB, M. D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED
2/23/62 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
2/26/62 | | | | 22c. NAME OF CEMETERY OR CREMATORY
Holy Rosary Cemetery Baltimore Co. Md. | | | |
| 23. FUNERAL DIRECTOR
John M. Weber & Sons Inc
ADDRESS
401 S. Chester St | | | | 24a. REC'D BY REGISTRAR
FEB 27 '62 | | | | 24b. REGISTRAR'S SIGNATURE
William S. Hanna | | | |

MEDICAL CERTIFICATION

01588

01588



John E. Kober & Sons Inc
101 S. Cooper St

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01704

CERTIFICATE OF DEATH

Reg. Dist. No. 01687

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Pikesville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>508 Reisterstown Rd.</u> | | d. STREET ADDRESS <u>508 Reisterstown Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Carroll V. Zink, Sr.</u> | | 4. DATE OF DEATH Month Day Year <u>Feb. 9 1962</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 2, 1887</u> |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self emp.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Conrad Zink</u> | | 14. MOTHER'S MAIDEN NAME <u>Pauline Wand</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>218-32-4183</u> | |
| 17. INFORMANT <u>Mrs. Genera Zink - 508 Reisterstown Rd</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>442X Cardio-Renal - Vascular Disease.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO</u>
(c) <u>DUE TO</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept 9 1959</u> , to <u>Feb 9 1962</u> , that I last saw the deceased alive on <u>February 7 1962</u> , and that death occurred at <u>1:20 A.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>412 Medical Arts Building Baltimore 1, Md.</u> DATE SIGNED <u>George E. Shannon</u> | | | |
| ACTUAL SIGNATURE <u>George E. Shannon</u> | | M.D. <u>412 Medical Arts Building</u> | |
| PHYSICIAN'S NAME (Type) <u>Baltimore 1, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Feb. 12, 1962</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u> | | 22d. LOCATION (City, town, or county) (State) <u>Pikesville Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury - 6411 Windsor Mill Rd.</u> | | ADDRESS <u>Baltimore 1, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>Feb 13 '62</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u> | |

CERTIFICATE OF DEATH

01704

| | | | |
|--|--|---|--|
| <p>1. Name of deceased: <u>James Earl Ray</u></p> | | <p>2. Date of birth: <u>May 19, 1928</u></p> | |
| <p>3. Sex: <u>Male</u></p> | | <p>4. Race: <u>White</u></p> | |
| <p>5. Date of death: <u>May 23, 1968</u></p> | | <p>6. Place of death: <u>Prison, St. Louis, Mo.</u></p> | |
| <p>7. Cause of death: <u>Heart disease</u></p> | | <p>8. Manner of death: <u>Natural</u></p> | |
| <p>9. Signature of physician: <u>[Signature]</u></p> | | <p>10. Signature of registrar: <u>[Signature]</u></p> | |
| <p>11. Date of registration: <u>May 24, 1968</u></p> | | <p>12. Place of registration: <u>St. Louis, Mo.</u></p> | |